Blue Cross® and Blue Shield® Service Benefit Plan

2000

A Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product

Administered by the Blue Cross and Blue Shield Association

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP.

Enrollment code for this Plan:

101 High Option Self Only
102 High Option Self and Family
104 Standard Option Self Only
105 Standard Option Self and Family

Visit the OPM website at http://www.opm.gov/insure

and

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Introduction

Blue Cross® and Blue Shield® Service Benefit Plan

This brochure describes the benefits you can receive from the Blue Cross and Blue Shield Service Benefit Plan under its contract (CS 1039) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This Plan is underwritten by Participating Blue Cross and Blue Shield Plans which administer this Plan on behalf of the Blue Cross and Blue Shield Association and are referred to as Local Plans in this brochure.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000, and are shown on pages 4-5. You do not have a right to benefits that were available before January 1, 2000 unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to the Blue Cross and Blue Shield Service Benefit Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

How to use this brochure

This brochure has ten sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Fee-for-Service Plans (FFS). This Plan is a FFS plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.
4. What if we deny your claim or request for pre-authorization? This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. How to file a claim. Look here to find specific information on how to file claims with us.
7. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.
8. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.
9. Fee-for-Service Facts. This section contains information about precertification, protection against catastrophic expenses, and a definitions section.
10. FEHB Facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Fee-for-Service Plans

Fee-for-Service plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-Service plans let you choose your own physicians, hospitals, and other health care providers.

The FFS plan reimburses you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan. The type and extent of covered services vary by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

This FFS plan offers a Preferred provider organization (PPO) arrangement. This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copayment of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your provider is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level of benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90-day period expires.

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of the **High Option** Blue Cross and Blue Shield Service Benefit Plan premium will increase by 4.3% for Self Only or 3.6% for Self and Family.

Your share of the **Standard Option** Blue Cross and Blue Shield Service Benefit Plan premium will increase by 8.0% for Self Only or 7.2% for Self and Family.

We have eliminated the $50 prescription drug deductible applicable to drugs obtained from retail pharmacies under **both options**.

We no longer waive the copayment for prescription drugs obtained through the mail for members with Medicare Part B as primary payer. Under **High Option**, all members now pay $8 for generic and $14 for brand-name prescription drugs and supplies obtained through the Mail Service Prescription Drug Program. Under **Standard Option**, all members now pay $12 for generic and $20 for brand-name prescription drugs and supplies obtained through the mail. See pages 34-35.

Under **High Option**, we no longer waive or reduce the coinsurance for prescription drugs obtained from a retail pharmacy for members with Medicare Part B as primary payer, and all members will pay 15% PPA at Preferred retail pharmacies and 35% AWP at Non-preferred retail pharmacies. Previously, when Medicare Part B was the primary payer, the 15% PPA coinsurance at Preferred pharmacies was waived and the 35% AWP coinsurance at Non-preferred pharmacies was reduced to 15% AWP. See pages 34-35.

Under **Standard Option**, you now pay 25% PPA at Preferred retail pharmacies and 45% AWP at Non-preferred retail pharmacies. Previously, coinsurance was 20% PPA at Preferred retail pharmacies and 40% AWP at Non-preferred retail pharmacies. See pages 34-35.

Under **Standard Option**, we no longer waive or reduce the coinsurance for prescription drugs obtained from a retail pharmacy for members with Medicare Part B as primary payer who are confined to a nursing home. Previously, the 20% PPA coinsurance at Preferred retail pharmacies was waived and the 40% AWP coinsurance at Non-preferred retail pharmacies was reduced to 20% AWP. See pages 34-35.

Under **Standard Option**, you now pay 10% PPA, after the $200 calendar year deductible, for covered professional services rendered by Preferred providers. (Obstetrical care rendered by Preferred providers will continue to be paid in full.) Previously, your coinsurance was 5% PPA for these services. See pages 16, 17, and 27.

You now pay nothing after the associated office visit copayment for diagnostic and screening sigmoidoscopies when rendered by Preferred facilities or Preferred professionals on an outpatient basis. When rendered by Non-preferred facilities or Non-preferred professionals, benefits will be provided under Other Medical Benefits for one screening sigmoidoscopy every five years at age 50 or over (the visit charge associated with these screening sigmoidoscopies is not covered) and for all medically necessary diagnostic sigmoidoscopies. See pages 26, 28, and 31.

Coverage is now available for certain organ/tissue transplant procedures for chronic lymphocytic leukemia and indolent or non-advanced small cell lymphocytic lymphoma only when performed as part of a clinical trial. See pages 18 and 19.

Under this Plan's **Standard Option** Point-of-Service (POS) program, you now pay $10 for home, office, and clinic visits. This includes the copayments for home visits during covered home health care by nurses or home health aides, as well as outpatient physical, occupational and speech therapy. Previously, your copayment was $5 for these services. See the POS addendum for your service area for details.

Under this Plan's **Standard Option** Point-of-Service (POS) program, you now pay a $5 generic or a $15 brand-name copayment for prescription drugs and supplies when you use a POS retail pharmacy. You now pay a $12 generic or a $20 brand-name copayment for each prescription drug or refill when you use the mail service pharmacy. Previously, your copayments were $5 per generic and $10 per brand-name prescription obtained from a POS retail pharmacy, and $12 per prescription obtained through the mail. See the POS addendum for your service area for details.

Mail Service Prescription Drug Program copayments are now included under the Catastrophic Protection Benefit as out-of-pocket expenses. See page 49.

Coverage is now available for diabetic education. See page 29.

Coverage is now available for immunizations for Lyme disease and Hepatitis. See pages 26, 28 and 31.

Coverage is now available for cardiac rehabilitation services through case management under the flexible benefits option. See pages 6 and 41.

See pages 10 and 11 for additional information concerning Local Plans that do not have Participating providers or Member hospitals.

The benefit descriptions on pages 15-35 now indicate what you pay.

How do I keep my health care expenses down?

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of inpatient admissions and the flexible benefits option. Some include managed care options, such as PPO's, to help contain costs.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met (except for routine maternity admissions). You or your doctor must check with your Local Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on pages 47-48 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Local Plan has the authority to determine the most effective way to provide services. The Local Plan may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Local Plan may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Local Plan's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

PPO and Point of Service (POS)

PPO

This Plan has established Preferred provider organization (PPO) arrangements. You can receive covered services from PPO providers at a reduced cost. Be sure to look to see if there are PPO cost savings when you review the benefits described in this brochure. The Local Plan (or for pharmacies, PCS Health Systems, Inc.) is solely responsible for the selection of PPO providers and any questions regarding PPO providers should be directed to the Local Plan (or for pharmacies, PCS Health Systems, Inc.) (see pages 10, 11, and 54 for more information). Call your Local Plan to obtain the names of PPO providers and to verify continued participation as a PPO provider.

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. The availability of every specialty in all areas cannot be guaranteed. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

POS

This Plan offers a Point-of-Service (POS) program under **Standard Option** in the following Local Plan areas: Connecticut, Georgia, Kansas, Louisiana (New Orleans area), Massachusetts, Minnesota, New Jersey, New York (areas served by the Empire Plan), North Dakota (Fargo area), Ohio (Cincinnati area), and Oklahoma. The POS program provides a higher level of benefits when services are provided or referred by a primary care physician selected by the member, while providing **Standard Option** Non-preferred benefits for services received without a referral. An addendum and a POS selection form are available from the Local Plans in the areas noted above that outline service areas, benefit levels, and special requirements of the POS program.

How much do I pay for services?

You must share the cost of some services. These cost sharing measures include deductibles, coinsurance and copayments. These and other measures are described in more detail below.

Deductibles

A deductible is the amount of expense you must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of expenses you must incur for covered services and supplies each calendar year before the Plan pays certain benefits. The calendar year deductible is

$150 per person under **High Option** and $200 per person under **Standard Option**. The calendar year deductible applies to all covered services and supplies except for certain Inpatient Hospital Benefits, Facility Benefits—Outpatient Surgery, Additional Benefits, Prescription Drug Benefits, **Standard Option** Dental Benefits, or, under **High Option**, Surgical Benefits and Maternity Benefits.

If the Billed charge for services you receive is less than the remaining portion of your deductible, you pay the Billed charge. If the Billed charge is more than the remaining portion of your deductible, you pay the remaining portion, and you and the Plan pay the stated percentage of the amount of the Covered charge remaining, if any (see the discussion of coinsurance below).

If you change options in this Plan during the calendar year, the amount of covered expenses already applied toward the deductible of your old option will be credited to the deductible of your new option.

Hospital admission

The per admission deductible is the amount of covered hospital room and board expenses you must incur during each Non-preferred hospital admission before the Plan pays benefits. The per admission deductible is $100 under **High Option** and $250 under **Standard Option**.

Family limit

There is a separate calendar year deductible of $150 per person under **High Option** and $200 per person under **Standard Option.** Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $300 under **High Option** and $400 under **Standard Option.**

Coinsurance

Coinsurance is the stated percentage of Covered charges you must pay after you have met any applicable deductibles. The Plan will base this percentage on either the Billed charge or the Allowable charge, whichever is less. For instance, when under **Standard Option** this Plan pays 75% of the Allowable charge (see Definitions) for a covered service, you are responsible for the coinsurance, which is 25% of the Allowable charge. In addition, you will be responsible for any excess charge over the Plan's Allowable charge when you use a Non-participating physician or pharmacy. For example, if a Non-participating physician ordinarily charges $100 for a service, but the Plan's Allowable charge (NPA) is $65 (determined by using the greater of the Medicare participating fee schedule amount for the service ($65) or 80% of the Plan's usual, customary and reasonable amount (80% of $80=$64)), the Plan will pay 75% of the Allowable charge (75% of $65=$48.75). You must pay the 25% coinsurance of the Allowable charge ($16.25), plus the difference between the Billed charge and the Allowable charge ($35), for a total member responsibility of $51.25.

Remember, if you use Preferred or Participating physicians and pharmacies, your share of Covered charges (after meeting any deductible) is limited to the stated coinsurance amounts based on the Allowable charge in most Local Plan areas (see pages 10 and 11 for exceptions). If you use Non-participating physicians or pharmacies, your out-of-pocket costs will be higher, as shown in the example above.

Your local Blue Cross and Blue Shield Plan negotiates payment arrangements with Preferred and Member hospitals and other facilities, and with Preferred and Participating physicians and other professional providers, that result in overall cost containment. The amounts these providers agree to accept as payment in full are generally, but not always, lower than the Billed charge (see Definitions for an explanation of Preferred and Member rates, Preferred and Participating Provider Allowances, and Billed charge under Covered charges). For services of these providers, your coinsurance will be based on the lesser of the Billed charge or the negotiated amount that these providers have agreed to accept, including any savings the Local Plan realizes through discounts that are known and that can be accurately calculated at the time your claim is processed. If you are age 65 or older and not enrolled in Medicare, this may not apply (see pages 46 and 47). If you use Non-member facilities for inpatient care, the Plan will pay its percentage based on the Billed charge or Average charge (see Definitions under Covered charges). You will be responsible for the coinsurance calculated on the Billed charge or Average charge and any excess charge over the Average charge.

Copayments

A copayment is the stated amount the Plan may require you to pay for a covered service, such as $12 per generic prescription by mail or $12 per office visit charge at a Preferred physician. For instance, when you visit a Preferred physician for a covered service, after you pay the $12 copayment, the Plan pays the remainder of the Preferred Provider Allowance (PPA).

For outpatient facility care and inpatient and outpatient mental conditions/substance abuse care in Preferred and Member hospitals, you are responsible for the least of the sum of the applicable per day copayments, the Billed charge, or the Preferred or Member rate, after you have met any

applicable deductibles. For example, if you receive four days of inpatient mental condition care at a Member hospital for which your copayments are $1,000 (4 x $250), the Billed charge is $900, and the Member rate is $800, you will be responsible for the Member rate ($800). For Non-member facilities, you will be responsible for the lesser of the sum of your copayments or the Billed charge.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments, or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but routinely waives the 25% coinsurance, the actual charge is $75. The Plan will pay $56.25 (75% of the actual charge of $75).

Lifetime maximums

Under **High** and **Standard Options**, benefits are limited to $100 per person per lifetime for one smoking cessation treatment program (see page 30).

Under **High** and **Standard Options**, inpatient care for treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per person per lifetime (see page 25).

When you change options within the Blue Cross and Blue Shield Service Benefit Plan, you and any covered family members are entitled to new benefits subject to the deductibles, limitations, exclusions, and definitions of the new option. Benefit amounts accrued under **High Option** or **Standard Option** are accumulated in a permanent record regardless of the number of enrollment changes.

Do I have to submit claims?

You usually do not have to submit claims to us if you use Preferred providers. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Please see Section 6, How to file a claim, for specific information you need to know before you file a claim with us.

Who provides my health care?

In a Fee-for-Service plan, you may choose any covered facility or provider.

Covered facilities

Covered facility providers include:

Preferred Facility – A facility that has an agreement with a local Blue Cross or Blue Shield Plan to accept the Plan's Preferred rate for services to Plan members. Contact your Local Plan to find out if the facility you are interested in is a Preferred facility.

Member Facility – A facility that has an agreement with a local Blue Cross or Blue Shield Plan to accept the Plan's Member rate for services to Plan members. Contact your Local Plan to find out if the facility you are interested in is a Member facility.

Non-Member Facility – A facility that is not a Preferred or Member facility.

Freestanding ambulatory facilities

- **Freestanding Ambulatory Facility**— A freestanding facility which meets the following criteria:

1. Your services are performed in an outpatient setting that is not generally considered an office or clinic for the private practice of a doctor or other professional;
2. The facility contains permanent amenities and equipment primarily for the purpose of performing medical, surgical and/or renal dialysis procedures; and
3. Your treatment will be provided by or under the supervision of doctors and/or nurses, and may include other ancillary professional services performed at the facility.

Some examples of ambulatory facilities include freestanding ambulatory medical facilities, ambulatory surgical centers, freestanding surgi-centers, and freestanding dialysis centers. In addition, we may, at our discretion, recognize any other like facilities as freestanding ambulatory facilities.

Hospitals

- **Hospital** – An institution, or distinct part of an institution, that 1) for compensation from its patients and on an inpatient basis is engaged primarily in providing diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons by or under the supervision of a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.); 2) continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and 3) is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a

custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

College infirmaries are considered Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

Skilled nursing facilities

- **Qualified Skilled Nursing Facility**—A facility that:
  1) specializes in skilled care and meets Medicare's special qualifying criteria, and
  2) has the staff and equipment to provide skilled nursing care performed by, or under the supervision of, licensed nursing personnel, or skilled rehabilitation services such as physical therapy performed by, or under the supervision of, a professional therapist, and other related health services.

  The term qualified skilled nursing facility does not include any institution that primarily cares for and treats mental diseases.

Cancer research facilities

- **Cancer Research Facility**—A facility that is: 1) a National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a bone marrow transplant center; 2) an NCI-designated Cancer Center; or 3) an institution that has an NCI-funded, peer-reviewed grant to study allogeneic or autologous bone marrow transplants and blood stem cell transplant support.

Others

- Others as set forth within the benefits description.

How facilities are paid

See Definitions for an explanation of Preferred rate, Member rate, Non-member rate, Average charge, and Billed charge under Covered charges.

Covered providers

Covered professional providers include:

- **Physician**—Doctors of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), and optometry (O.D.), when acting within the scope of their licenses, are considered physicians.
- **Attending Physician**—The physician who has responsibility for the care and treatment of the member on an inpatient basis. A consulting physician who is an employee of the hospital in which the member is an inpatient is not the attending physician.

The following are considered covered providers when they perform covered services within the scope of their license or certification:

- **Independent Laboratory**—A laboratory that is licensed under State law or, where no licensing requirement exists, is approved by the Local Plan.
- **Qualified Clinical Psychologist**—A psychologist who 1) is licensed or certified in the state where the services are performed, 2) has a doctoral degree in psychology or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree, or meets the requirements of the Carrier, and 3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Nurse Midwife**—A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.
- **Nurse Practitioner/Clinical Specialist**—A person who 1) has an active R.N. license in the United States, 2) has a baccalaureate or higher degree in nursing, and 3) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.

- **Clinical Social Worker**—A social worker who 1) has a master's or doctoral degree in social work, 2) has at least two years of clinical social work practice, and 3) in states requiring licensure, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered.
- **Nursing School Administered Clinic**—A clinic that is 1) licensed or certified in the state where the services are performed, and 2) provides ambulatory care in an outpatient setting—primarily in rural or inner-city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient "office" services rather than facility charges.
- Others as set forth within the benefits description.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 2000, the States designated as medically underserved are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, South Carolina, South Dakota, Utah, and Wyoming.

How providers are paid

There are four types of Allowable charges: the Preferred Provider Allowance (PPA), which applies to charges from Preferred professional providers and pharmacies; the Participating Provider Allowance (PAR), which applies to charges from Participating professional providers; the Non-participating Provider Allowance (NPA), which applies to charges from Non-participating professional providers; and the Average Wholesale Price (AWP), which applies to charges from Non-preferred pharmacies. (See Definitions for an explanation of Allowable charges under Covered charges, and Preferred, Participating, and Non-participating physicians.) Most Preferred physicians accept 100% of the PPA as payment in full (see below for exceptions). In most cases, when you use a Preferred physician, you are responsible for your coinsurance (after any applicable deductible has been met), and are not responsible for any covered expense in excess of the PPA.

Note: Providers who contract with more than one Local Plan may be Preferred in one area and Participating in a different area. To verify the status of a provider, contact the Local Plan serving the area where services are rendered.

Participating physicians usually accept 100% of the Local Plan's PAR as payment in full. That means when you use a Participating physician, you are usually only responsible for your coinsurance for covered services (after any applicable deductible has been met), and are not responsible for any covered expense in excess of the PAR. In some Plan areas, physicians who were formerly Participating physicians are now Preferred physicians for the purposes of this Plan.

In the following areas, there are Preferred physicians but no Participating physicians for the purposes of either option of this Plan:

Alabama	Kansas	Puerto Rico
Alaska	Mississippi	South Carolina
California Blue Shield	Nevada	Tennessee
Connecticut	New Hampshire	Vermont
Illinois	New Jersey	Wyoming
	New York areas served by the Empire and Rochester Plans	

Non-participating physicians, on the other hand, may, but are not required to, accept the Local Plan's NPA as payment in full. These physicians may bill you up to their charge, even after the Local Plan has paid its portion of your bill. Members may be held responsible for any amounts over the NPA, in addition to applicable coinsurance amounts, copayment amounts, amounts applied to the calendar year deductible, and noncovered services. **It is important that you are aware that your out-of-pocket costs may be higher when you use Non-participating physicians.**

In the following areas, there are Preferred hospitals but no Member hospitals for the purposes of either option of this Plan:

Alabama	Nevada	Pennsylvania areas
Connecticut	New Hampshire	served by the
Illinois	New Jersey	Harrisburg Plan
Kansas	New York areas served by	Rhode Island
Maine	the Buffalo, Empire,	Vermont
Maryland	Rochester and	Wyoming
Montana	Utica/Watertown Plans	

When this Plan pays primary or secondary benefits

In all Local Plan areas other than those described below, Preferred physicians will accept 100% PPA as payment in full and Participating physicians will accept 100% PAR as payment in full for covered services. As a result, you are only responsible for applicable coinsurance amounts, copayment amounts, amounts applied to the calendar year deductible, and noncovered services. Any balance above the applicable Allowable charge (PPA or PAR) billed by a Preferred or Participating physician under either **High Option** or **Standard Option** should be brought to the attention of the Local Plan.

Exception when this Plan pays primary

- In Arizona, if there is secondary coverage not administered by this Plan, or other source of payment, Preferred and Participating physicians are not obligated to accept the PPA or PAR as payment in full.

Exceptions when this Plan pays secondary

- In Puerto Rico, Preferred physicians can collect the difference between the Plan's payment and the physician's charge.
- In Montana, Preferred and Participating physicians can collect the difference between the Plan's payment and the physician's charge.
- In Pennsylvania and Utah, the agreement described above applies only when the Local Plan makes a payment as the secondary payer to other coverage (see pages 45-47).
- In the following areas, Preferred and Participating physicians can collect the difference between the Plan's payment and the physician's charge except when this Plan pays secondary to other Blue Cross and Blue Shield coverage:

New York areas served by the Rochester* Plan	South Carolina
Rhode Island	Vermont
	West Virginia*

*The above agreement applies only when the primary coverage is administered by the same Local Plan.

Areas outside the United States and Puerto Rico

The Washington, DC Plan processes overseas claims (see page 40 for instructions on submitting overseas claims) at Preferred levels based on an Overseas Fee Schedule. You are responsible for the difference between the Plan's payment and the provider's charge.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at the telephone number listed on the back of your Service Benefit Plan identification card. If you are new to the FEHB Program, we will reimburse your covered expenses. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- You exhaust the benefits available from your former plan; or
- The 92nd day after you became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

What if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. If it is, you may be able to continue seeing your provider for up to 90 days after you receive notice that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in the second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

If you continue seeing your specialist or OB/GYN under these conditions, your cost will be no more than you would normally pay for the services covered.

How do I decide if a service is experimental or investigational?

Each Local Plan has a Medical Review department that makes these determinations after consulting with internal or external experts or nationally-recognized guidelines in a particular field or specialty. For more detailed information, contact your Local Plan at the telephone number located on the back of your identification card.

Experimental or investigational

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Section 4. What if we deny your claim or request for pre-authorization?

What should I do before filing a disputed claim?

Before you ask us to reconsider your claim, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did the provider use the correct procedure code for the services performed (surgery, laboratory test, X-ray, office visit, etc.)? Have your provider indicate any complications of any surgical procedures performed. Your provider should also include copies of an operative or procedure report, or other documentation that supports your claim.

If we deny your request for pre-authorization or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing;
2. Refer to specific brochure wording in explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;

3. Approve your request for pre-authorization; or
4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life-threatening condition and you haven't responded to my request for pre-authorization?

Call us at the telephone number located on the back of your identification card and we will expedite our review.

What if you have denied my claim for care and my condition is serious or life-threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment, too. Alternatively, you can call OPM's health benefits Contracts Division I at (202) 606-0727 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division I, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Inpatient Hospital Benefits

What is covered

The Plan provides coverage for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission **must** be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 47-48 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States. For information on when Medicare is primary, see page 43.

Room and board and Other charges

The Plan provides coverage at the benefit levels indicated below for services provided by the following facilities when furnished and billed as regular inpatient hospital services:

	High Option	Standard Option
PPO/Preferred hospitals	You pay nothing for unlimited days	You pay nothing for unlimited days
Member hospitals	After you pay a $100 per admission deductible, you pay nothing for unlimited days	After you pay a $250 per admission deductible, you pay nothing for unlimited days
Non-member hospitals	In the United States and Puerto Rico, you pay a $100 per admission deductible under **High Option**; you pay a $250 per admission deductible under **Standard Option**. In addition, you pay 30% of the Non-member rate (see Definitions) **and** any remaining balance after the Plan has made its payment. You pay nothing for facilities outside of the United States and Puerto Rico.	

Note: You should be aware that some Preferred hospitals may have Non-preferred providers on staff. Following is a list of some of the frequently referred providers about whose Preferred status you should inquire to help ensure that you receive your maximum benefits: Radiologist, Pathologist, Anesthesiologist, and Assistant Surgeon.

Room and board

Covered services are noted below:

- Semiprivate accommodations
- Intensive care units

Private room

A private room is covered only when the patient's isolation is required by law; when the Carrier determines that isolation is medically necessary to prevent contagion; or, in Preferred and Member hospitals, when the hospital only offers private rooms.

In noncovered private accommodations and in other noncovered accommodations, the Plan pays the hospital's average daily rate for semiprivate accommodations, which is determined by the Local Plan. Other hospital services are paid as shown above.

Other hospital charges

- Operating, recovery, and other treatment rooms
- Drugs and medical supplies

- X-rays, Magnetic Resonance Imagings (MRIs), laboratory and pathological services, and machine diagnostic tests
- Dressings, splints, plaster casts
- Anesthetics and anesthesia service
- Administration of blood and blood plasma; see page 29 for coverage of blood and blood products
- Pre-admission testing recognized as part of the hospital admissions procedures

Limited benefits

Hospitalization for dental work

The Plan pays for room and board and other hospital services for hospitalization in connection with dental procedures only when a nondental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient.

Chemotherapy/ radiation therapy

Chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants or blood stem cell transplant support is only covered for specific diagnoses (see Organ/tissue transplants and donor expenses under Surgical Benefits on pages 17-20).

Related benefits

Outpatient hospital benefits

See pages 26-27 for outpatient hospital care benefits and outpatient surgery/facility care benefits.

Surgical benefits

See pages 17-20 for surgical benefits when provided, or ordered, and billed by a physician.

Other charges

See Other Medical Benefits for coverage of blood, drugs, and ambulance transport services.

Inhospital physician care

The Plan provides coverage at the benefit levels indicated below for the following nonsurgical services provided, or ordered, and billed by a physician:

	High Option	Standard Option
PPO/Preferred physicians	You pay **5% PPA**	After you pay the $200 calendar year deductible, you pay **10% PPA**
Participating physicians	You pay **20% PAR**	After you pay the $200 calendar year deductible, you pay **25% PAR**
Non-participating physicians	You pay **20% NPA**. You are also responsible for the difference between the Plan's payment and the physician's actual charge	After you pay the $200 calendar year deductible, you pay **25% NPA**. You are also responsible for the difference between the Plan's payment and the physician's actual charge

See Definitions for an explanation of: Preferred, Participating, and Non-participating physicians, and PPA, PAR, and NPA under Covered charges.

- Medical care by the attending physician on days covered by Inpatient Hospital Benefits
- Intensive physician care by the attending physician for treatment of a condition other than that for which surgical or maternity care is required
- Consultations when requested by the attending physician, not including routine radiological and staff consultations required by hospital rules and regulations
- Concurrent care (see Definitions)
- Physical therapy when provided by a physician other than the attending physician

What is not covered

Room and board and inhospital physician care when, in the Carrier's judgment, a hospital admission or portion of an admission is one of the following types:

- Custodial care (see Definitions)
- Convalescent care or a rest cure
- Domiciliary care provided because care in the home is not available or is unsuitable
- Inpatient private duty nursing
- Not medically necessary, *i.e.*, for services that did not require the acute hospital inpatient (overnight) setting, but could have been provided in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting the patient's condition or the quality of medical care rendered. Some examples are:

  —admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, *e.g.*, physician's office

  —admissions primarily for diagnostic studies (X-rays, Magnetic Resonance Imagings (MRIs), laboratory and pathological services, and machine diagnostic tests) that could have been provided safely and adequately in some other setting, *e.g.*, outpatient department of a hospital or physician's office

If a hospital admission is determined to be one of the types listed above, the Plan will pay benefits for services or supplies other than room and board and inhospital physician care at the level at which they would have been covered if provided in some other setting.

Surgical Benefits

What is covered

The Plan provides coverage at the benefit levels indicated below, except as noted, for the following services provided, or ordered, and billed by a physician:

	High Option	**Standard Option**
PPO/Preferred physicians	You pay **5% PPA**	After you pay the $200 calendar year deductible, you pay **10% PPA**
Participating physicians	You pay **20% PAR**	After you pay the $200 calendar year deductible, you pay **25% PAR**
Non-participating physicians	You pay **20% NPA**. You are also responsible for the difference between the Plan's payment and the physician's actual charge	After you pay the $200 calendar year deductible, you pay **25% NPA**. You are also responsible for the difference between the Plan's payment and the physician's actual charge

See Definitions for an explanation of: Preferred, Participating, and Non-participating physicians, and PPA, PAR, and NPA under Covered charges.

Surgical services

- Operative or cutting procedures, including treatment of fractures and dislocations, surgical sterilization, and normal pre- and post-operative care by the operating physician
- Diagnostic procedures such as endoscopies and biopsies
- Treatment of burns
- Surgical correction of congenital anomalies (see Definitions)

- Extraction or reinfusion of bone marrow, blood stem cells, or cord blood as a source of stem cells as part of an allogeneic or autologous bone marrow transplant or blood stem cell transplant support procedure, including marrow harvesting in anticipation of a covered autologous bone marrow transplant, for patients diagnosed at the time of harvesting with one of the conditions listed on pages 18-19. The collection, processing, storage and distribution of cord blood must be performed by a cord blood bank approved by the FDA. Expenses for storage of harvested bone marrow, blood stem cells, or cord blood as a source of stem cells are **not** covered, unless the covered transplant has already been scheduled
- When unusual circumstances require removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable
- Surgical correction of amblyopia and strabismus

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays these multiple, bilateral, or incidental surgical (combined) procedures on the basis of the Allowable charge that is determined by the Local Plan. The Plan determines which procedure is primary and which procedures are secondary, tertiary, etc., and provides a reduced allowance for the non-primary procedures.

Assistant surgeon (inpatient/outpatient)

Surgical assistance by a physician if required by the complexity of the surgical procedure.

Anesthesia (inpatient/outpatient)

Anesthesia service (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician, other than the operating physician or the assistant, for covered surgical services. CRNAs are reimbursed at the payment levels indicated above for Participating and Non-participating physicians.

Organ/tissue transplants and donor expenses

What is covered

The following human organ/tissue transplant procedures:

- Allogeneic bone marrow transplant and allogeneic cord blood stem cell transplant (from related or unrelated donors) for 1) Advanced neuroblastoma; 2) Infantile malignant osteopetrosis; 3) Severe combined immunodeficiency; 4) Wiskott-Aldrich syndrome; 5) Mucopolysaccharidosis (*e.g.*, Hunter, Hurler's, Sanfilippo, Maroteaux-Lamy variants); 6) Mucolipidosis (*e.g.*, Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy); 7) Severe or very severe aplastic anemia; 8) Thalassemia major (homozygous beta-thalassemia); and 9) Sickle cell anemia.
- Allogeneic bone marrow transplant, allogeneic cord blood stem cell transplant (from related or unrelated donors) and allogeneic peripheral blood stem cell transplant for 1) Acute lymphocytic or non-lymphocytic (*i.e.*, myelogenous) leukemia; 2) Advanced Hodgkin's lymphoma; 3) Advanced non-Hodgkin's lymphoma; 4) Chronic myelogenous leukemia; and 5) Advanced forms of myelodysplastic syndromes.
- Autologous bone marrow transplant and autologous peripheral blood stem cell transplant (collectively referred to as autologous stem cell support) for 1) Acute lymphocytic or nonlymphocytic (*i.e.*, myelogenous) leukemia; 2) Advanced Hodgkin's lymphoma; 3) Advanced non-Hodgkin's lymphoma; 4) Advanced neuroblastoma; 5) Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors; and 6) Multiple myeloma.
- Allogeneic bone marrow transplant, syngeneic bone marrow transplant, and allogeneic peripheral blood stem cell transplant for 1) Multiple myeloma; 2) Chronic lymphocytic leukemia; and 3) early stage (indolent or non-advanced) small cell lymphocytic lymphoma; and autologous bone marrow transplant and autologous peripheral blood stem cell transplant (collectively referred to as autologous stem cell support) for 1) Breast cancer; 2) Epithelial ovarian cancer; 3) Chronic myelogenous leukemia; 4) Chronic lymphocytic leukemia; and 5) early stage (indolent or non-advanced) small cell lymphocytic lymphoma; only when performed as part of a clinical trial that meets the requirements noted in the Limitations below and is conducted at a Cancer Research Facility (see page 9).

In the event no non-randomized clinical trials meeting the requirements set forth below are available at Cancer Research Facilities for a member eligible for such clinical trials, the Plan will make arrangements for the transplant to be provided at another Plan-designated transplant facility.

Related services or supplies provided to the recipient are covered, including chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants or blood stem cell transplant support, and drugs or medications administered to stimulate or mobilize stem cells for the transplant procedures described above.

- Single or double lung transplants for the following end-stage pulmonary diseases: 1) Pulmonary fibrosis, 2) Primary pulmonary hypertension, and 3) Emphysema. Double lung transplant for end-stage cystic fibrosis.
- Cornea
- Heart
- Heart-lung
- Small bowel
- Kidney
- Liver
- Pancreas

Related medical and hospital expenses of the donor are covered.

Limitations

- Prior approval by the Local Plan of the procedure and the facility is required for bone marrow, cord blood stem cell, and peripheral blood stem cell transplant support procedures, heart, heart-lung, liver, lung, pancreas, and small bowel transplants (see page 48)
- For the bone marrow transplant procedures and related services or supplies covered only through clinical trials:

1. Prior approval by the Carrier is required (see page 48);
2. The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered; and
3. The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial.

What is not covered

Services or supplies for or related to artificial or human organ/tissue transplants for any diagnosis not specifically listed as covered. Related services or supplies for noncovered procedures, including chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants, cord blood stem cell transplants (from related or unrelated donors), or peripheral blood stem cell transplant support, drugs or medications administered to stimulate or mobilize stem cells for transplant, and all other services or supplies which would not be medically necessary or appropriate but for the noncovered procedure.

Oral and maxillofacial surgery

Limited to the following surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is required
- Surgery needed to correct accidental injuries (see Definitions) to jaws, cheeks, lips, tongue, roof and floor of mouth
- Excision of exostoses of jaws and hard palate
- External incision and drainage of cellulitis
- Incision and surgical treatment of accessory sinuses, salivary glands or ducts
- Reduction of dislocations and excision of temporomandibular joints
- Removal of impacted teeth

Mastectomy surgery

Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance (see page 20).

Reconstructive surgery

Benefits will be provided for:

- Treatment to restore the mouth to a pre-cancer state.
- Breast reconstruction surgery following a mastectomy, including surgery to produce a symmetrical appearance on the other breast. Benefits will be provided for all stages of breast reconstruction following a mastectomy, including treatment of any physical complications, including lymphedemas, and for breast prostheses, including surgical bras and replacements.

Related benefits

Outpatient surgery/ facility care benefits

Outpatient surgical services billed for by a facility are covered under Other Medical Benefits. See page 27.

What is not covered

- Cosmetic surgery (see Definitions) unless required for a congenital anomaly or to restore or correct a part of the body which has been altered as a result of accidental injury, disease, or surgery
- Radial keratotomy and other refractive surgeries
- Services for or related to reversal of surgical sterilization

Maternity Benefits

What is covered

The Plan provides coverage at the benefit levels indicated below for services provided by the following facilities when furnished and billed as regular inpatient hospital services. The mother, at her option, may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary.

Inpatient hospital

Precertification

Precertification is **not** required for maternity admissions for routine deliveries. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, your physician or the hospital must contact the Local Plan for certification of additional days. The Plan will not pay for charges incurred on any extra days that are not medically necessary. See pages 47-48 for details.

	High Option	Standard Option
PPO/Preferred hospitals	You pay nothing for unlimited days	You pay nothing for unlimited days
Member hospitals	After you pay a $100 per admission deductible, you pay nothing for unlimited days	After you pay a $250 per admission deductible, you pay nothing for unlimited days
Non-member hospitals	In the United States and Puerto Rico, you pay a $100 per admission deductible under **High Option**; you pay a $250 per admission deductible under **Standard Option**. In addition, you pay 30% of the Non-member rate (see Definitions) **and** any remaining balance after the Plan has made it's payment. You pay nothing for facilities outside of the United States and Puerto Rico.	

Covered services are noted below:

Room and board

Room and board and other hospital services. (See Inpatient Hospital Benefits for a description of all covered services, and payment levels for Non-member hospitals.)

Private room

A private room is covered only when the patient's isolation is required by law; when the Carrier determines that isolation is medically necessary to prevent contagion; or, in Preferred and Member hospitals, when the hospital only offers private rooms.

In noncovered private accommodations and in other noncovered accommodations, the Plan pays the hospital's average daily rate for semiprivate accommodations, which is determined by the Local Plan. Other hospital services are paid as shown above.

Bassinet and nursery

Hospital bassinet or nursery charges for days in which both the mother and newborn are confined in the hospital are considered as expenses of the mother and not expenses of the child. When a newborn requires definitive treatment (including incubation charges by reason of prematurity), or evaluation for medical or surgical reasons, during or after the mother's confinement, the newborn is considered a patient in his or her own right and a separate per admission deductible, if applicable, applies. Expenses of the newborn (including circumcision) are eligible for benefits only if the child is covered by a Self and Family enrollment. See page 48 for information on requesting additional days for a covered newborn confined beyond the mother's discharge date.

Other charges

- Operating, recovery, and other treatment rooms
- Drugs and medical supplies
- Other covered ancillary services

Outpatient care

Outpatient hospital care for delivery including care in freestanding ambulatory facilities, including birthing centers, is covered as described under Other Medical Benefits, Outpatient surgery—Facility care benefits (see page 27).

Note: When you use Preferred facilities, benefits for obstetrical care, including prenatal testing, are provided **in full**, not subject to the calendar year deductible or copayment.

Professional care

The Plan provides coverage at the benefit levels indicated below for services provided, or ordered, and billed by a physician or nurse midwife:

	High Option	Standard Option
PPO/Preferred physicians	You pay nothing	You pay nothing
Participating physicians/Nurse midwives	You pay **20% PAR**	After you pay the $200 calendar year deductible, you pay **25% PAR**
Non-participating physicians/Nurse midwives	You pay **20% NPA**. You are also responsible for the difference between the Plan's payment and the physician's actual charge	After you pay the $200 calendar year deductible, you pay **25% NPA**. You are also responsible for the difference between the Plan's payment and the physician's actual charge

See Definitions for an explanation of: Preferred, Participating, and Non-participating physicians, and PAR and NPA under Covered charges.

Obstetrical care

- Physician care for pregnancy (including related conditions) and resulting childbirth or miscarriage
- Services of a licensed or certified nurse midwife for pre- and post-partum care and delivery
- Anesthesia services, services of a nurse anesthetist, and surgical assistance as described under Surgical Benefits

Related benefits

Contraceptive devices and drugs

- Intrauterine devices (IUDs), Norplant, Depo-Provera, diaphragms, and oral contraceptives obtained from a physician are covered at the levels indicated on page 17; when obtained from a facility, they are covered at Other Medical Benefit levels (see page 27)
- IUDs, Norplant, Depo-Provera, diaphragms, and oral contraceptives dispensed by a retail pharmacy are covered as prescription drugs (see page 34)
- Oral contraceptives are also covered under the Mail Service Prescription Drug Program (see page 34)

Diagnosis and treatment of infertility

Diagnosis and treatment of infertility are covered at the benefit levels indicated on page 17; related prescription drugs are covered under Prescription Drug Benefits (see pages 34-35); see exclusion below for Assisted Reproductive Technology (ART) procedures.

Prenatal testing

Prenatal testing is covered at the benefit levels shown above and on page 27.

Voluntary sterilization

Sterilization procedures (see page 17 for benefits for surgical sterilization).

Well child care

Well child care is covered under Additional Benefits (see page 31).

For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

What is not covered

- Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer, and GIFT, as well as services and supplies related to ART procedures, including sperm banking
- Reversal of voluntary sterilization
- Contraceptive devices, except as specifically described above

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan provides coverage at the benefit levels indicated below for services provided by the following facilities and professionals when furnished and billed as regular inpatient hospital services:

Mental conditions

Note: Please check with your Local Plan and/or PPO directory for listings of Preferred facilities and contracted professional providers.

Inpatient care

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 47-48 for details.

Hospital care

	High Option	Standard Option
PPO/Preferred hospitals	You pay a $75 per day copayment for up to 120 days; you pay all charges thereafter	You pay a $150 per day copayment for up to 100 days; you pay all charges thereafter
Member hospitals	You pay a $150 per day copayment for up to 120 days; you pay all charges thereafter	You pay a $250 per day copayment for up to 100 days; you pay all charges thereafter
Non-member hospitals	You pay a $300 per day copayment for up to 120 days; you pay all charges thereafter. In addition, you pay the difference between the Plan's payment and the provider's actual charge	You pay a $400 per day copayment for up to 100 days; you pay all charges thereafter. In addition, you pay the difference between the Plan's payment and the provider's actual charge

After you pay the per day copayments, the Plan pays the remainder of the Preferred rate, Member rate, or Non-member rate in excess of the sum of your copayments. In Preferred and Member hospitals, in some instances, when the Preferred or Member rate or the Billed charge is less than the sum of your copayments, you will be responsible only for the lowest amount. In Non-member hospitals, in some instances, the Average charge may be less than the sum of your copayments.

See the definition of Covered charges for an explanation of Preferred rate, Member rate, Non-member rate, Billed charge, and Average charge. See also the discussion of copayments on pages 7-8.

Covered services include room and board and other hospital services (see Inpatient Hospital Benefits for a description of all covered services).

Inpatient visits

The Plan provides coverage at the benefit levels indicated below for inpatient mental conditions and substance abuse professional care rendered by Participating and Non-participating providers:

High Option	Standard Option
After you pay the $150 calendar year deductible, you pay **20%** of the **Allowable charge** (see Definitions)	After you pay the $200 calendar year deductible, you pay **40%** of the **Allowable charge** (see Definitions)

Outpatient care

The Plan pays all covered outpatient care (including related services and supplies, such as psychological testing) for the treatment of a mental condition, including substance abuse, as follows:

Facility care

	High Option	Standard Option
	After you pay the $150 calendar year deductible, you pay the following copayments:	After you pay the $200 calendar year deductible, you pay the following copayments:
PPO/Preferred facilities	You pay $10	You pay $25
Member facilities	You pay $50	You pay $100
Non-member facilities	You pay $100	You pay $150

These copayments will be applied per facility per day, not per service. After meeting the deductibles, you will be responsible for the lesser of the stated copayment or the Billed charge(s). If Preferred or Member facilities are available, and utilized, you will be responsible for the lesser of the stated copayments, the Billed charge(s), or the Preferred or Member rate at the time your claim is processed.

Professional care

The Plan provides coverage at the benefit levels described below for outpatient mental conditions and substance abuse professional care rendered by Participating and Non-participating providers:

High Option	Standard Option
After you pay the $150 calendar year deductible, you pay **30%** of the **Allowable charge** (see Definitions)	After you pay the $200 calendar year deductible, you pay **40%** of the **Allowable charge** (see Definitions)

Therapy

Outpatient visits are available up to **50 visits** under **High Option** and **25 visits** under **Standard Option** per person per calendar year for:

- Individual or group therapy, or combination of individual and group therapy, up to two hours per day, including collateral visits with members of the patient's immediate family, provided by a physician, qualified clinical psychologist, psychiatric nurse, or clinical social worker
- Day-night hospital services (sometimes called partial hospitalization)

The number of visits for which you receive reimbursement will be reduced if these services are used to meet part or all of your calendar year deductible.

Substance abuse

Inpatient care

The Plan provides benefits for the inpatient treatment of alcoholism and drug abuse at the levels indicated on the previous page for hospital care and inpatient visits for mental conditions care. Treatment is also payable in a freestanding alcoholism facility approved by the Local Plan.

Lifetime maximum

Inpatient care for the treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime under **High** and **Standard Options**.

Outpatient care

The Plan provides benefits for outpatient facility and professional care for the treatment of substance abuse at the benefit levels indicated above. Outpatient visits accrue toward the visit limits described above.

What is not covered

- Marital, family, educational, or other counseling or training services
- Services rendered or billed by a school or halfway house or a member of its staff
- Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present
- Services and supplies that are not medically necessary (see Definitions and General Exclusions)

Other Medical Benefits

What is covered

Except as noted, after any applicable deductibles and copayments have been met, the Plan pays the following:

Outpatient facility care

	High Option	Standard Option
	After you pay the $150 calendar year deductible, you pay the following copayments:	After you pay the $200 calendar year deductible, you pay the following copayments:
PPO/Preferred facilities	You pay $10	You pay $25
Member facilities	You pay $50	You pay $100
Non-member facilities	You pay $100	You pay $150

These copayments will be applied per facility per day, not per service. After meeting the deductible, you will be responsible for the lesser of the stated copayments or the Billed charge(s). If Preferred or Member facilities are available, and utilized, you will be responsible for the lesser of the stated copayments, the Billed charge(s), or the Preferred or Member rate at the time your claim is processed.

Covered services, 1) when furnished by the hospital outpatient department, ordered by a physician, and billed by a hospital, or 2) for renal dialysis, when furnished and billed by a freestanding ambulatory facility (see Facilities and Other Providers), are as follows:

Diagnostic services

X-rays, Magnetic Resonance Imagings (MRIs), laboratory and pathological services, and machine diagnostic tests. Certain diagnostic cancer tests are covered differently when provided by a Preferred facility (see page 31).

Preventive services

In **Member** and **Non-member** facilities, each cervical cancer screening, mammogram for breast cancer screening, fecal occult blood test for colorectal cancer screening, sigmoidoscopy for colorectal cancer screening, PSA (Prostate Specific Antigen) test for prostate cancer screening, tetanus-diphtheria (Td) booster, and immunization for influenza, pneumonia, and Lyme disease is paid as described above. See page 28 for the screening schedules related to these tests and immunizations for Member and Non-member facilities and for Participating and Non-participating providers. These services are covered differently when you use Preferred providers (see page 31).

Other outpatient services

- Radiation therapy, chemotherapy, and renal dialysis (chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants or blood stem cell transplant support is covered only for those covered conditions as described under Organ/tissue transplants and donor expenses under Surgical Benefits on pages 18-19)
- Physical, occupational, and speech therapy (for visit limitations, see page 30)
- Allergy tests, surveys, and injections, blood (as described under Miscellaneous services on page 29), and prescription drugs, billed for by the facility
- Hepatitis immunizations for patients with increased risk or family history
- Hospital services in connection with dental procedures only when a nondental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient
- Pharmacotherapy (see pages 34-35 for coverage for prescription drugs)

Outpatient surgery

Facility care benefits

The Plan provides coverage at the benefit levels indicated below, not subject to the calendar year deductible, for the outpatient surgical services listed below when billed for by a facility:

	High Option	Standard Option
	You pay nothing but the following copayments:	You pay nothing but the following copayments:
PPO/Preferred facilities	You pay $10	You pay $25
Member facilities	You pay $50	You pay $100
Non-member facilities	You pay $100	You pay $150

These copayments will be applied per facility per day, not per service. You will be responsible for the lesser of the stated copayments or the Billed charge(s). If Preferred or Member facilities are available, and utilized, you will be responsible for the lesser of the stated copayments, the Billed charge(s), or the Preferred or Member rate at the time your claim is processed.

Overseas care—You pay nothing for outpatient surgical services at hospitals located outside the United States or Puerto Rico.

Covered facility-billed services are noted below:

- Surgical services and related other hospital services
- Related X-rays, Magnetic Resonance Imagings (MRIs), laboratory and pathological services, and machine diagnostic tests performed within one business day of the covered surgical services. (Presurgical testing performed more than one business day prior to the surgery is covered as described on page 26 under Outpatient Facility Care – Diagnostic services.)
- Facility supplies for hemophilia home care

Physician care

Except as noted, the Plan provides coverage at the benefit levels indicated below for services provided, or ordered, and billed by a physician:

	High Option	Standard Option
PPO/Preferred physicians	After you pay the $150 calendar year deductible, you pay **5% PPA**	After you pay the $200 calendar year deductible, you pay **10% PPA**
Participating physicians	After you pay the $150 calendar year deductible, you pay **20% PAR**	After you pay the $200 calendar year deductible, you pay **25% PAR**
Non-participating physicians	After you pay the $150 calendar year deductible, you pay **20% NPA**. You are also responsible for the difference between the Plan's payment and the physician's actual charge	After you pay the $200 calendar year deductible, you pay **25% NPA**. You are also responsible for the difference between the Plan's payment and the physician's actual charge

See Definitions for an explanation of: Preferred, Participating, and Non-participating physicians, and PPA, PAR, and NPA under Covered charges.

Home and office visits

When you use Preferred physicians, home and office visits, physicians' outpatient consultations, and second surgical opinions are paid **in full** under **High** and **Standard Options** after a $12 copayment for each outpatient office visit charge. These services are paid as described above when rendered by Participating and Non-participating physicians.

Diagnostic services

- X-rays, Magnetic Resonance Imagings (MRIs), laboratory and pathological services, and machine diagnostic tests, including mammograms and Pap smears. Certain diagnostic cancer tests are covered differently when provided by a Preferred provider (see page 31).
- Laboratory and pathological services billed by an independent laboratory

Preventive services

The following routine (screening) procedures are paid as described above when performed by **Participating** and **Non-participating** providers. These services are covered differently when you use Preferred providers, and the visit charge associated with these services is covered only with Preferred providers; see Additional Benefits, page 31.

The following schedules are applicable for Member and Non-member facilities and Participating and Non-participating providers.

Breast cancer screening

Mammograms are covered for females age 35 and older as follows:

- From age 35 through 39, one mammogram screening during this five-year period
- From age 40 through 64, one mammogram screening every calendar year
- At age 65 or over, one mammogram screening every two consecutive calendar years

Cervical cancer screening

One Pap smear for females of any age every calendar year.

Colorectal cancer screening

- One fecal occult blood test for members age 40 and older every calendar year
- One sigmoidoscopy for members age 50 and older every five years

Prostate cancer screening

One PSA (Prostate Specific Antigen) test for males age 40 and older every calendar year.

Immunizations

- For influenza and pneumonia, once every calendar year
- Tetanus-diphtheria (Td) booster, once every ten calendar years
- Lyme disease vaccine

Other outpatient services

- Radiation therapy, chemotherapy, and renal dialysis (chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants or blood stem cell transplant support is covered only for those covered conditions as described under Organ/tissue transplants and donor expenses under Surgical Benefits on pages 17-20)
- Physical, occupational, and speech therapy (for visit limitations, see page 30)
- Allergy tests, surveys, and injections, blood as described on page 29, and prescription drugs
- Hepatitis immunizations for patients with increased risk or family history
- Under **High Option**, physician home visits when receiving covered home health care (see page 32)
- Covered services provided by a nurse midwife acting within the scope of licensure
- Pharmacotherapy (see pages 34-35 for coverage for prescription drugs)

Other services

Except as noted, benefits for the following services are paid as follows:

High Option	Standard Option
After you pay the $150 calendar year deductible, you pay **20%** of the **Allowable charge** (see Definitions)	After you pay the $200 calendar year deductible, you pay **25%** of the **Allowable charge** (see Definitions)

Note: Preferred and Participating providers may not be available for the following services in your area. When they are available, and utilized, the Plan pays benefits as shown under **Physician care** on page 27.

Ambulance

Professional ambulance transport services:

- associated with covered hospital inpatient care;
- related to and within 72 hours after an accidental injury or medical emergency; or
- during covered home health care.

Dental care for accidental injury

Services, supplies, or appliances for dental care to sound natural teeth (see Definitions) required as a result of, and directly related to, an accidental injury (see Definitions).

Durable medical equipment

- Rental by the member or purchase, at the Carrier's option if it will be less expensive, of durable medical equipment (such as respirators and home dialysis equipment) including replacement, repair, and adjustment of purchased equipment
- Wheelchairs, hospital beds, crutches, and other items determined by the Carrier to be durable medical equipment

Home nursing care

Care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.), when the care is ordered by a physician. Home nursing care is available for two (2) hours per day up to **50 visits** per calendar year under **High Option** and **25 visits** per calendar year under **Standard Option**. The number of visits for which you receive reimbursement will be reduced if these services are used to meet part or all of your calendar year deductible.

Miscellaneous services and supplies

- Allergy tests, surveys, and injections
- Blood and blood plasma except when donated or replaced, and blood plasma expanders
- Neurological testing when rendered and billed by a qualified clinical psychologist
- One set of eyeglasses or contact lenses, or one replacement to an existing prescription, required as a result of, and directly related to, a single instance of intra-ocular surgery or a single ocular injury. This benefit also applies when, in situations as described above, the condition can be corrected by surgery, but surgery is precluded (*i.e.*, cannot be performed because of age or medical complications), and lenses are prescribed in lieu of surgery
- Ostomy and catheter supplies
- Oxygen, regardless of the provider
- Medical foods for children with inborn errors of amino acid metabolism
- Prescription drugs not billed by a retail pharmacy (excludes those drugs obtained through the Mail Service Prescription Drug Program)
- Home infusion therapy (prescription drugs; medical supplies; durable medical equipment (DME); and home nursing visits, subject to the calendar year visit limitations described above under Home nursing care)
- Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 12
- Functional foot orthotics when medically necessary and prescribed by a physician
- Rigid devices attached to the foot or a brace or placed in a shoe
- Acupuncture as a modality of physical therapy and for pain management when rendered and billed by a physician or licensed physical therapist
- Orthopedic braces and prosthetic appliances (such as artificial legs and pacemakers) including replacement, repair, and adjustment
- Diabetic education when billed by a covered provider

Physical, occupational, and speech therapy

Physical, occupational, and speech therapy when rendered by a physical, occupational, or speech therapist who is licensed or meets the requirements of the Carrier, by a physician rendered on an outpatient basis, or by an outpatient facility. When billed by a skilled nursing facility, nursing home or extended care facility, benefits will be paid as shown on page 27 for professional care, according to the contracting status of the professional provider that actually performs the therapy. The following limits apply to outpatient care:

- Physical therapy: **75 visits** under **High Option** and **50 visits** under **Standard Option** per person per calendar year
- Occupational therapy, speech therapy, or a combination of both: **25 visits** under **High** and **Standard Options** per person per calendar year

The number of visits for which you receive reimbursement will be reduced if these services are used to meet part or all of your calendar year deductible.

See page 16 for physical, occupational, and speech therapy provided by a physician on an inpatient basis. See pages 26-28 for payment levels for outpatient physical, occupational, and speech therapy provided by a physician or outpatient facility.

Limited benefits

Smoking cessation benefit

After satisfaction of the calendar year deductible, under **High** and **Standard Options**, the Plan will pay **100%** of Billed charges up to a maximum payment of $100 for enrollment in one smoking cessation program per member per lifetime. Services may be rendered by any covered provider or by a smoking cessation clinic.

See pages 34-35, Prescription Drug Benefits, for coverage of smoking cessation drugs.

What is not covered

- Exercise and bathroom equipment
- Lifts, such as seat, chair, or van lifts
- Air conditioners, humidifiers, dehumidifiers, and purifiers
- Shoes and over-the-counter orthotics
- Wigs
- Breast pumps
- Implanted bone conduction hearing aids
- Computer “story boards” or “light talkers” for communication-impaired individuals
- Maintenance or palliative physical, occupational, or speech therapy for a chronic disease or condition which does not require the technical proficiency or the skill and training of a physician or qualified physical, occupational, or speech therapist, except during acute exacerbations of the disease or condition
- Home nursing care when:
  1) Requested by, or for the convenience of, the patient or the patient’s family; or
  2) It consists primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication, or acting as a companion or sitter.

Additional Benefits

Preventive services provided by Preferred providers

The Plan provides coverage for each home and office visit for a routine physical examination at the benefit levels indicated below when provided by a Preferred physician or Preferred facility:

After you pay a $12 copayment, you pay nothing under **High Option**

After you pay a $12 copayment, you pay nothing under **Standard Option**

Routine physical examination

Home and office visits for routine (screening) examination, consisting of a history and risk assessment, chest X-ray, electrocardiogram (EKG), urinalysis, basic metabolic or comprehensive metabolic panel test, and complete blood count (CBC), are covered for members as follows:

- Through age 64, once every three consecutive calendar years
- At age 65 or over, once every calendar year

This benefit does not apply to children eligible for Well Child Care benefits.

Additionally, the preventive (screening) tests and immunizations noted below are paid **in full** when provided by a Preferred physician or a Preferred facility on an outpatient basis, subject to the schedules indicated. If these services are rendered by a Preferred physician separately from the routine physical examination, you will be responsible for the $12 copayment for each associated office visit.

Coronary artery disease screening

Cholesterol tests are covered for members as follows:

- Through age 64, once every three consecutive calendar years
- At age 65 or over, once every calendar year

This benefit does not apply to children eligible for Well Child Care benefits.

Preventive (screening) cholesterol tests are only covered and paid **in full** when provided by Preferred providers or any independent laboratory.

Immunizations

- For influenza and pneumonia, once every calendar year
- Tetanus-diphtheria (Td) booster, once every ten calendar years
- Lyme disease vaccine

See pages 26-28, Other Medical Benefits, for benefits for these immunizations provided by Member and Non-member facilities and Participating and Non-participating providers. **The visit charge associated with these services is covered only with Preferred facilities or Preferred providers.**

Cancer tests (diagnostic/screening) provided by Preferred providers

The following diagnostic and screening cancer tests are paid in full when provided by a Preferred facility or a Preferred professional provider on an outpatient basis. You are responsible for the $12 copay for each associated office visit:

- Mammogram
- Pap smear
- Fecal occult blood test
- Sigmoidoscopy
- PSA (Prostate Specific Antigen) test

See pages 26-28, Other Medical Benefits, for payment levels and applicable schedules for these diagnostic and preventive services provided by Member and Non-member facilities and Participating and Non-participating physicians. **The visit charge associated with these services is covered only with Preferred facilities or Preferred providers.**

Well child care

For children up to age 22, you pay nothing under **High** and **Standard Options** for Covered charges for the following covered routine services for well child care:

- All healthy newborn inpatient physician visits, including routine screening (inpatient or outpatient)
- Routine physical examinations, laboratory tests, immunizations, and related office visits, including those for children living, traveling, or adopted from outside the United States, as recommended by the American Academy of Pediatrics

Accidental injury (outpatient care)

You pay nothing under **High** and **Standard Options** for Covered charges for the following covered services and supplies in connection with, and within 72 hours after, accidental injury (see Definitions):

- Other hospital services in Preferred, Member, and Non-member hospitals, including related X-rays, Magnetic Resonance Imagings (MRIs), laboratory and pathological services, and machine diagnostic tests
- Physician services in the office or hospital outpatient department, including X-rays, Magnetic Resonance Imagings (MRIs), laboratory and pathological services, and machine diagnostic tests

See Definitions for an explanation of Preferred, Participating, and Non-participating physicians, and Covered charges.

Related benefits

The following related services are covered under Other Medical Benefits (see pages 26-30):

- Services related to accidental injury rendered more than 72 hours after the injury
- Care for accidental dental injury
- Ambulance transport services

Home health care

High Option

You pay nothing under **High Option** for the covered home health care services listed below for up to 90 days per calendar year if:

1) the services rendered are billed by a home health care agency (such as the hospital or a visiting nurse association) that has a written agreement with the Local Plan to provide home health care services, and
2) prior approval is obtained from the Local Plan. If prior approval is not obtained, Other Medical Benefits will be provided as applicable.

Note: The member has the responsibility to make sure that the home health care provider has received prior approval from the Local Plan (see pages 48-49 for instructions). Please check with your Local Plan and/or your PPO directory for listings.

What is covered

- Nursing care such as dressing changes, injections, and monitoring of vital signs
- Physical therapy
- Respiratory or inhalation therapy
- Prescription drugs
- Medical supplies which serve a specific therapeutic or diagnostic purpose
- Infusion therapy
- Other medically necessary services or supplies that would have been provided by a hospital if the member was hospitalized
- See page 28 for **High Option** coverage for physician home visits while receiving covered home health care services

What is not covered

- Home health care services related to the treatment of mental conditions/substance abuse, for routine maternity care, for routine monitoring of a condition, for intermittent care of a stable condition, or for initial evaluation of the patient to determine whether or not home health care is appropriate
- Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter

Standard Option

See page 29 for **Standard Option** coverage of home nursing care.

Home hospice care

You pay nothing under **High** and **Standard Options** if prior approval is obtained from the Local Plan for covered home hospice services rendered to members with a life expectancy of six months or less when billed by a home hospice care agency which is approved by the Local Plan.

Note: You are responsible to make sure that the home hospice care provider has received prior approval from the Local Plan (see page 48 for instructions). Please check with your Local Plan and/or your PPO directory for listings.

What is covered

- Physician visits
- Nursing care
- Medical social services
- Physical therapy
- Services of home health aides
- Durable medical equipment rental
- Prescription drugs
- Medical supplies

Related inpatient services

Inpatient hospice benefits are available only to a member receiving Home hospice care benefits. Benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility. These covered inpatient hospice benefits are available only when inpatient services are necessary to control pain and manage the symptoms of the patient or to provide an interval of relief to the family (respite).

Each inpatient stay must be separated by at least 21 days. You pay nothing under **High** and **Standard Options** when you are admitted to a Preferred hospital. If you are admitted to a Member or Non-member hospital, you pay $100 per admission deductible under **High Option** and you pay a $250 per admission deductible under **Standard Option**. (See page 15 for Inpatient Hospital Benefits.)

What is not covered

- Homemaker or bereavement services

Limited benefits

Skilled nursing facilities

When Medicare Part A is primary payer (it pays first) and has made payment, **High** and **Standard Options** provide secondary benefits for the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period, as defined by Medicare, in a qualified skilled nursing facility (see page 9). If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day, when Medicare Part A copayments begin, and will end on the 30th day.

24-Hour nurse telephone service

Help with health concerns is available 24 hours a day, 365 days a year, by calling a toll-free telephone number 1-888/258-3432 or accessing an Internet web site www.Bluehealth.org. The service, called Blue Health Connection, features health advice or health information and counseling by registered nurses. Also available is the AudioHealth Library with hundreds of tapes, ranging from first aid to infectious diseases to general health issues. You can get information about health care resources to help you find local doctors, hospitals or other health care services affiliated with the Blue Cross and Blue Shield Service Benefit Plan. This service is offered in certain pilot areas, and will become available in additional areas during 2000. Contact us at the number above or visit our web site for more information.

We will send a membership kit and other information about Blue Health Connection in the mail to enrollees who live in the states where this service is available.

Patient support programs

The Service Benefit Plan is developing and may offer patient support programs for certain diagnoses in select locations on a pilot basis.

Prescription Drug Benefits

What is covered

You may purchase up to a 90-day supply of the following medications and supplies prescribed by a doctor from either a pharmacy or by mail; however, quantities may be limited for certain drugs such as narcotics:

- Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Needles and disposable syringes for the administration of covered medications
- Intrauterine devices (IUDs), Norplant, Depo-Provera, diaphragms, and oral contraceptives dispensed by a retail pharmacy; and oral contraceptives obtained through the Mail Service Prescription Drug Program
- Drugs to aid smoking cessation that require a prescription by Federal law (limited to one regimen per calendar year)

In most cases, refills cannot be obtained until 75% of the drug has been used. Call the Retail Pharmacy Program (1-800/624-5060 / TDD: 1-800/624-5077) or the Mail Service Prescription Drug Program (1-800/262-7890 / TDD: 1-800/446-7292) for exceptions to this policy. Not all drugs are available through the Mail Service Program.

You can save money by using generic drugs. By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute a Federally approved generic equivalent, if available, unless you or your physician specifically requests a name brand.

What is not covered

- Medical supplies such as dressings and antiseptics
- Drugs and supplies for cosmetic purposes
- Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law
- Drugs prescribed for weight loss
- Drugs for orthodontic care, dental implants, and periodontal disease
- Drugs for which prior approval has been denied

From a pharmacy

You may purchase up to a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. Call 1-800/624-5060 (TDD: 1-800/624-5077) to locate a Preferred pharmacy in your area.

	High Option	Standard Option
PPO/Preferred retail pharmacies	You pay **15% PPA**	You pay **25% PPA**
Non-preferred retail pharmacies	You pay **35% AWP**. You are also responsible for the difference between the Plan's payment and the pharmacy's actual charge	You pay **45% AWP**. You are also responsible for the difference between the Plan's payment and the pharmacy's actual charge

You must present your Plan ID card at the time of purchase at a Preferred pharmacy. You are only responsible for the applicable coinsurance at the time of purchase. All Preferred retail pharmacies will file claims for you. Preferred pharmacies will receive the payment and agree to accept 100% of the PPA as payment in full. At Non-preferred retail pharmacies, you must pay the full cost at the time of purchase and submit a claim. You are responsible for the applicable coinsurance based upon the Average Wholesale Price (AWP), and any amounts in excess of the allowance. Certain prescription drugs and supplies may require prior approval (see pages 35 and 48-49). Any savings received by the Carrier on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

To claim benefits

Use a retail prescription drug claim form for prescription drugs and supplies purchased at Non-preferred retail pharmacies. You may obtain these forms by calling 1-800/624-5060 (TDD: 1-800/624-5077). Follow the instructions on the form and mail it to the Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

By mail

If your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you may order your prescription or refill by mail from the Mail Service Prescription Drug Program. Merck-Medco Rx Services will fill your prescription.

You pay an $8 generic and $14 brand-name copayment under **High Option** and a $12 generic and $20 brand-name copayment under **Standard Option** for each prescription drug, supply, or refill you purchase through the Mail Service Prescription Drug Program.

To claim benefits

The Plan will send you information on the Mail Service Prescription Drug Program. To use the Program:

1) Complete the initial mail order form.
2) Enclose your prescription and copayment.
3) Mail your order to Merck-Medco Rx Services, P.O. Box 30492, Tampa, FL 33633-0144.
4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800/262-7890 (TDD: 1-800/446-7292). You will be billed later for the copayment. After that, to order your refill you may either call the same number or access this Plan's website at http://www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. You should allow approximately one week for delivery.

Prior approval

Certain prescription drugs and supplies may require prior approval before they will be covered under this Plan, and prior approval must be renewed periodically. Call 1-800/624-5060 (TDD: 1-800/624-5077) to obtain an updated list of prescription drugs and supplies that require prior approval. Once prior approval has been obtained or renewed, you may take advantage of electronic claims processing at Preferred pharmacies, have claims paid for drugs and supplies purchased from Non-preferred pharmacies, or have drugs and supplies dispensed by the Mail Service Prescription Drug Program.

Retail Pharmacy Program

The Retail Pharmacy Program will request the medical evidence needed to make its coverage determination. Drugs and supplies that require prior approval also require 1) payment in full at time of purchase (including Preferred pharmacies) and 2) the member's submission of the expense(s) on a claim form. Preferred pharmacies will not file these expenses for you.

Mail Service Program

Merck-Medco Rx Services will screen all prescription drugs prior to dispensing. If the drug or supply requires prior approval, your prescription will not be filled until prior approval has been obtained. The prescription will be returned to you along with a Prior Approval Request form and a letter explaining the program and procedures.

Drugs from other sources

Prescription drugs and certain supplies not purchased from a retail pharmacy or through the Mail Service Prescription Drug Program are covered at Other Medical Benefits levels when billed for by an outpatient facility or a physician (see pages 26-28), or Additional Benefits levels when billed for by a covered home health care agency (see page 32) or home hospice agency (see page 33). When hospitalized, drugs and supplies are covered under Inpatient Hospital Benefits (see page 15) or Maternity Benefits (see page 22).

Purchasing drugs when you are overseas

Claims for covered prescription drugs and supplies purchased outside of the United States and Puerto Rico should be submitted on an Overseas Claim Form and sent to the Overseas Claims Section address listed on page 40. These drugs must be equivalent to drugs that by Federal law of the United States require a prescription.

Prescription drugs requiring constant refrigeration cannot be shipped to APO/FPO boxes by the Mail Service Prescription Drug Program.

Coordinating with other drug coverage

When you use a Preferred retail pharmacy and this Plan is the primary payer, you must call the Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program at 1-800/624-5060 (TDD: 1-800/624-5077) to request a statement of benefits for other coverage purposes.

Standard Option Dental Benefits

What is covered

The Plan will pay Billed charges, for the following services, up to the amount specified in the Schedule of Dental Allowances below. This is a complete list of covered dental benefits for **Standard Option**. These benefits are **not** available under **High Option**.

Preferred Dental Network

The PPO now includes Preferred dentists who are available in all Local Plans in most areas. Preferred dentists agree to accept a negotiated, discount amount called the Maximum Allowable Charge (MAC) as payment in full for the services listed below. These dentists may not be Preferred for other services covered by this Plan under other benefit provisions (such as oral and maxillofacial surgery or Other Medical Benefits). They will also file your dental claims for you. You are responsible, as an out-of-pocket expense, for the difference between the amount specified on this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you or to obtain a copy of the MAC listing applicable to your area, contact your Local Plan.

Complete schedule of dental allowances

	ADA Code		Up to Age 13	Age 13 and over
Clinical oral evaluations	0120	Periodic oral evaluation*	$ 12	$ 8
	0140	Limited oral evaluation	14	9
	0150	Comprehensive oral evaluation	14	9
	0160	Detailed and extensive oral evaluation	14	9
Radiographs	0210	Intraoral—complete series	$ 36	$22
	0220	Intraoral—periapical—first film	7	5
	0230	Intraoral—periapical—each additional film	4	3
	0240	Intraoral—occlusal film	12	7
	0250	Extraoral—first film	16	10
	0260	Extraoral—each additional film	6	4
	0270	Bitewing—single film	9	6
	0272	Bitewings—two films	14	9
	0274	Bitewings—four films	19	12
	0277	Bitewings—vertical	12	7
	0290	Posterior-anterior or lateral skull and facial bone survey film	45	28
	0330	Panoramic film	36	23
Tests and laboratory exams	0460	Pulp vitality tests	$ 11	$ 7
Palliative treatment	9110	Palliative (emergency) treatment of dental pain—minor procedure	$ 24	$15
	2940	Sedative filling	24	15
Preventive	1120	Prophylaxis—child*	$ 22	$14
	1110	Prophylaxis—adult*	—	16
	1201	Topical application of fluoride (including prophylaxis)—child*	35	22
	1203	Topical application of fluoride (prophylaxis not included)—child	13	8
	1205	Topical application of fluoride (including prophylaxis)—adult*	—	24
	1204	Topical application of fluoride (prophylaxis not included)—adult	—	8
Space maintenance (passive appliances)	1510	Space maintainer—fixed—unilateral	$ 94	$59
	1515	Space maintainer—fixed—bilateral	139	87
	1520	Space maintainer—removable—unilateral	94	59
	1525	Space maintainer—removable—bilateral	139	87
	1550	Recementation of space maintainer	22	14

* Limited to two per person per calendar year

	ADA Code		Up to Age 13	Age 13 and over
Amalgam restorations (including polishing)	2110	Amalgam—one surface, primary	$22	$14
	2120	Amalgam—two surfaces, primary	31	20
	2130	Amalgam—three surfaces, primary	40	25
	2131	Amalgam—four or more surfaces, primary	49	31
	2140	Amalgam—one surface, permanent	25	16
	2150	Amalgam—two surfaces, permanent	37	23
	2160	Amalgam—three surfaces, permanent	50	31
	2161	Amalgam—four or more surfaces, permanent	56	35
Filled or unfilled resin restorations	2330	Resin—one surface, anterior	$25	$16
	2331	Resin—two surfaces, anterior	37	23
	2332	Resin—three surfaces, anterior	50	31
	2335	Resin—four or more surfaces or involving incisal angle (anterior)	56	35
	2380	Resin—one surface, posterior-primary	22	14
	2381	Resin—two surfaces, posterior-primary	31	20
	2382	Resin—three or more surfaces, posterior-primary	40	25
	2385	Resin—one surface, posterior-permanent	25	16
	2386	Resin—two surfaces, posterior-permanent	37	23
	2387	Resin—three surfaces, posterior-permanent	50	31
	2388	Resin—four or more surfaces, posterior-permanent	50	31
Inlay restorations	2510	Inlay—metallic—one surface	$25	$16
	2520	Inlay—metallic—two surfaces	37	23
	2530	Inlay—metallic—three or more surfaces	50	31
	2610	Inlay—porcelain/ceramic—one surface	25	16
	2620	Inlay—porcelain/ceramic—two surfaces	37	23
	2630	Inlay—porcelain/ceramic—three or more surfaces	50	31
	2650	Inlay—composite/resin—one surface	25	16
	2651	Inlay—composite/resin—two surfaces	37	23
	2652	Inlay—composite/resin—three or more surfaces	50	31
Other restorative services	2951	Pin retention—per tooth, in addition to restoration	$13	$ 8
Extractions—includes local anesthesia and routine post-operative care	7110	Single tooth	$30	$19
	7120	Each additional tooth	27	17
	7130	Root removal—exposed roots	71	45
Surgical extractions—includes local anesthesia and routine post-operative care	7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43	$27
	7250	Surgical removal of residual tooth roots (cutting procedure)	71	45
Anesthesia	9220	General anesthesia in connection with covered extractions	$43	$27

Oral and maxillofacial surgery or accidental injury

For covered oral and maxillofacial surgery or dental care related to accidental injury, see pages 19 and 29.

Note: Please check the Preferred status of your dentist or oral surgeon before receiving oral surgery. A Preferred dentist who accepts the MAC as payment in full for the dental services listed above may not be a Preferred provider for oral surgical procedures or other services covered under other benefit provisions of this Plan.

What is not covered

Any dental procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or the continued use of dentures, except as specifically described or referenced. See General Exclusions.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copayment charges, etc. These benefits are not subject to the FEHB disputed claims review procedure.

Vision Care Program

Service Benefit Plan members may obtain eye exams and eyewear at substantial savings from Cole Managed Vision One providers. The names, addresses, and telephone numbers of Vision One providers are available by calling

1-800/551-3337. Location information is available 24 hours a day; Customer Service is available from 9:00 a.m. to 9:00 p.m. EST Monday through Friday and from 9:00 a.m. to 5:00 p.m. EST Saturday.

You may also obtain your contact lenses through the Vision One Contact Lens Replacement Program. Call

1-800/987-5367 and ask for Dept. 701.

There are no enrollment fees and no additional paperwork or claim forms to be filed in this program. All charges for eye exams and eyewear are handled directly between you and the Vision One provider.

Discount Vitamin Program

Service Benefit Plan members may obtain a selection of over 150 non-prescription vitamins, minerals, and herbal products at a substantial savings when ordered through Bio-Balance, a mail order discount program offered by Landmark/Leiner Health Products. You may order products or request a catalog by calling 1-877/258-7283. Customer Service is available from 8:00 a.m. to 9:00 p.m. EST Monday through Friday and from 8:00 a.m. to 6:00 p.m. EST Saturday.

There are no enrollment fees and no additional paperwork or claim forms to be filed in this program. All charges for products offered by the Discount Vitamin Program are handled directly between you and Bio-Balance.*

Federal DentalBlue (Standard Option Only)

Federal DentalBlue is an optional dental product with an additional premium that supplements the dental benefits included in your **Standard Option** coverage. To apply for Federal DentalBlue, you must be enrolled in **Standard Option** and reside in a Plan area listed below. To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your Local Plan.

Federal DentalBlue is available only in the following Plan areas:

Alabama
Massachusetts
Oklahoma
Washington areas served by the Regence Plan

Many Blue Cross and Blue Shield Plans not offering Federal DentalBlue do offer dental insurance outside and apart from the FEHB Program. If interested, contact your Local Plan about availability of a non-FEHB dental program in your area.

Medicare Prepaid Plan Enrollment

Many local Blue Cross and Blue Shield Plans offer Medicare recipients the opportunity to enroll in a Medicare prepaid plan without payment of an FEHB premium. Contact your local Blue Cross and Blue Shield Plan to find out if a Medicare prepaid plan is available in your area and the cost, if any, of that enrollment.

*The Blue Cross and Blue Shield Association and participating Local Plans will receive remuneration from Landmark/Leiner Health Products to cover administrative costs in offering the program and for other purposes.

Benefits on this page are not part of the FEHB contract.

Section 6. How to file a claim

Claim forms, identification cards and questions

For claim forms and other claims filing advice, contact your Local Plan. If you do not receive your identification card(s) within 60 days after the effective date of your enrollment you may contact the Local Plan serving the area in which you reside or write to: FEP Enrollment Services, 550 12th Street, SW, Washington, DC 20065-1463 to report the delay in receiving your card(s), to get replacement cards, to obtain your Plan identification number, or to obtain claim forms or other claims filing advice. Give your full name, address, date of birth, agency where employed, whether enrollment is for Self Only or Self and Family, whether **High** or **Standard Option,** and identification ("R") number, if known. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services.

If you have a question concerning Plan benefits, contact your Local Plan. You may also contact the Plan at its website at http://www.fepblue.org.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with providers.

How to claim benefits

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA-1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee
- Plan identification number of the enrollee
- Name and address of person or firm providing the service or supply
- Dates that services or supplies were furnished
- Type of each service or supply and the charge
- Diagnosis

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as the Medicare Summary Notice (MSN)) must be sent with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not ordered through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- Translation and currency conversion services will be provided by the Plan for claims for overseas (foreign) services.

Canceled checks, cash register receipts, or balance due statements are not acceptable.

Contact your Local Plan at the telephone number on the back of your identification card for information, claim forms, and assistance.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. The Carrier will not provide duplicate or year-end statements.

Submit claims promptly

All claims must be submitted no later than December 31 of the calendar year after the one in which the covered care or service was provided, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once benefits have been paid, there is a three-year limitation on the reissuance of uncashed checks.

Use a separate claim form for each family member. These procedures include prescription drugs that are not obtained from a retail pharmacy. See below for a description of how to claim benefits for retail pharmacy-obtained prescription drugs. When covered expenses exceed the deductible, complete a claim form, attach itemized bills, and send them to the Local Plan serving the area where the services were rendered. For services other than inpatient, you may send the claim to the Local Plan serving the area where you reside. File expenses quarterly thereafter. Claims payments for covered services submitted by you are usually sent to you.

If the Local Plan returns a claim or part of a claim for additional information, it must be resubmitted within 90 days, or before the timely filing period expires, whichever is later. For long or continuing hospital stays or other long-term care, claims must be submitted at least every 30 days.

For information about prescription drugs (including insulin, insulin-related disposable syringes, and other diabetic and non-diabetic supplies) obtained through the Mail Service Prescription Drug Program, see instructions on page 34-35.

Overseas claims

For covered services rendered in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Overseas Claim Form and the itemized bills to: NCA Processing Department, 550 12th Street, SW, Washington, DC 20065-8473, Attention: FEP Overseas Claims Section. Overseas Claim Forms can be obtained from this address or your Local Plan. Any written inquiries concerning the processing of overseas claims should be sent to this address.

Preferred and Member hospitals and facilities in the U.S. and Puerto Rico

Present your identification card when admitted or when you receive outpatient care. The hospital has the necessary forms and will submit them to the Local Plan. Benefits are paid to the hospital, which will bill you for any coinsurance, copayments, noncovered charges, or any charges applied to your calendar year deductible.

Preferred and Participating physicians in the U.S.

Always ask if the physician is a Preferred or Participating physician for purposes of this Plan. Present your identification card and sign the necessary forms. Benefits are usually paid to the physician, who will bill you for any coinsurance, copayments, noncovered services, or any charges applied to your calendar year deductible.

Prescription drug claims (Retail Pharmacy Program)

When you use Preferred retail pharmacies, show your Plan ID card. You pay the applicable coinsurance for your prescription drug. Preferred retail pharmacies will file your prescription drug claim for you. Reimbursement for covered drugs will be sent to pharmacies. Members who do not have a valid Plan ID card, who do not show their card at the time of purchase, or who failed to receive prior approval when required will have to file a paper claim form to obtain benefits for drugs purchased at Preferred pharmacies.

For Non-preferred retail pharmacy expenses, you should use a retail prescription drug claim form to claim benefits for retail pharmacy-obtained prescription drugs. Prescription drug claim forms may be obtained from Local Plans, or by calling 1-800/624-5060. Hearing-impaired members with TDD equipment can call 1-800/624-5077. Follow the instructions on the claim form and submit the completed form to:

Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program
P.O. Box 52057
Phoenix, AZ 85072-2057

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Section 7. General exclusions – Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness or condition. The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Procedures, services, drugs and supplies related to sex transformations, sexual dysfunction or sexual inadequacy;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan;
- Services where no charge would have been made if the covered individual had no health insurance coverage;
- Services furnished without charge (except as described on page 40); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment 1) as a result of an act of war within the United States, its territories, or possessions or 2) during combat;
- Services furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption;
- Services furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered;
- Services not specifically listed as covered;
- Services or supplies used for cosmetic purposes;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay, or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 46-47), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 44), or State premium taxes however applied;
- In the case of inpatient care, medical services which are not medically necessary, *i.e.*, those which did not require the acute hospital inpatient (overnight) setting, but could have been provided in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting the patient's condition or the quality of medical care rendered. Some examples are:
  - admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, *e.g.*, physician's office
  - admissions primarily for diagnostic studies (X-rays, Magnetic Resonance Imagings (MRIs), laboratory and pathological services, and machine diagnostic tests) which could have been provided safely and adequately in some other setting, *e.g.*, outpatient department of a hospital or physician's office;
- Standby physicians;
- Biofeedback and other forms of self-care or self-help training;
- Outpatient cardiac rehabilitation (except as offered through case management under the flexible benefits option);
- Any dental and oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or the continued use of dentures. These are covered only as described under **Standard Option** Dental Benefits, Dental care for accidental injury, Hospitalization for dental work, or Surgical Benefits for Oral and maxillofacial surgery;

- Orthodontic care for temporomandibular joint (TMJ) syndrome;
- Custodial care (see Definitions);
- Services and supplies furnished or billed by an extended care facility, nursing home, or other noncovered facility, except as specifically described on page 33. Medically necessary prescription drugs are covered;
- Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as provided for on page 29;
- Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described on page 29;
- Hearing aids or examinations for the prescribing or fitting of hearing aids;
- Treatment (including drugs) of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures;
- Personal comfort items such as beauty and barber services, radio, television, or telephone;
- Routine services (see Definitions), except for those Preventive services specifically described in this brochure on pages 26, 28, and 31. For purposes of this Plan, routine services include, but are not limited to, periodic physical examinations, screening examinations or tests, immunization shots, and X-rays, Magnetic Resonance Imagings (MRIs), laboratory and pathological services, and machine diagnostic tests that are not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care;
- Routine foot care, including corn or callus removal, or nail trimming;
- Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay or through an approved Home health care program;
- Assisted Reproductive Technology (ART) procedures and related services and supplies (see page 23);
- Services you receive from noncovered providers such as chiropractors, except as specifically described on page 10 under Coverage in medically underserved areas.

Section 8. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office, or call SSA at 1-800/638-6833. For information on the Medicare+Choice plan(s) offered by local Blue Cross and Blue Shield Plans, see page 38.

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to us; this applies whether or not you file a claim under Medicare. You must also give us authorization to obtain information about benefits or services denied or paid by Medicare when we request it. It is also important that you inform us about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see pages 42-44).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, except that primary benefits are not available from this Plan for qualified skilled nursing facility care, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both an FEHB plan and Medicare.

This Plan is primary if:

1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD), except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Medicare is primary if:

1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
5) You are enrolled in Part B only, regardless of your employment status;
6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;
8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is primary, all or part of your Plan deductibles, copayments, and coinsurance will be waived as follows:

Inpatient Hospital Benefits: If you are enrolled in Medicare Part A and Medicare is the primary payer, the Plan will waive the per admission deductible applicable in Member and Non-member hospitals and the Non-member hospital coinsurance. The requirement to precertify each hospital admission is also waived (also see pages 47-48). The Plan will not waive the difference between the Average charge and the Billed charge (see pages 50-52) at a Non-member hospital once Medicare benefits have been exhausted. If you are enrolled in Medicare Part B and Medicare is the primary payer, the Plan will waive the calendar year deductible and any coinsurance for inhospital physician care.

Surgical Benefits and Other Medical Benefits: If you are enrolled in Medicare Part B and Medicare is the primary payer, the Plan will waive the calendar year deductible, any coinsurance or outpatient facility copayments, and the $12 copayment for each home and office visit, physician outpatient consultation, and second surgical opinion. The Preferred, Member, and Non-member facility copayments for outpatient surgery are also waived.

Maternity Benefits: Deductibles, copayments, and coinsurance are waived the same as for Inpatient Hospital Benefits, Surgical Benefits, and Other Medical Benefits.

Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A and Medicare is the primary payer, the Plan will waive the inpatient hospital mental conditions/substance abuse per day copayments. If you are enrolled in Medicare Part B and Medicare is the primary payer, the Plan will waive the inpatient and outpatient professional care coinsurance, outpatient facility care copayments, and the calendar year deductible. Benefit limits will not be waived.

Additional Benefits: If you are enrolled in Medicare Part B and Medicare is the primary payer, the $12 copayment for each preventive (screening) physical examination provided by a Preferred physician or facility is waived.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment, that is, they have agreed not to bill you for more than the **Medicare-approved amount** for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the **limiting charge**, is 115 percent of the Medicare-approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid **only** if the Medicare and Plan payments combined do not total the limiting charge.

Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. The Medicare Summary Notice (MSN) will have more information about this limit.

If your doctor does not participate with Medicare, asks you to pay more than the limiting charge **and** he or she is under contract with this Plan, call the Plan. If your doctor is **not** a Plan doctor, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare Summary Notice (MSN). In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. To be sure your claims are processed by this Carrier, you must submit the Medicare Summary Notice (MSN) and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare Summary Notice (MSN).

Claims should show both your Plan identification number (8 digits preceded by "R") and your Medicare identification number which is on your Medicare card. Claims for benefits which are not covered by Medicare should be sent directly to your Local Plan. See page 40 for information on how retail pharmacy-obtained drug expenses are filed.

Other group insurance coverage

When anyone has coverage with us and with another group health plan it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine how much of the charge we will pay for. After the first plan pays, we will pay either what is left of our allowable charge or our regular benefit, whichever is less. We will not pay more than our allowable charge. When we pay secondary, we will generally only make up the difference between the primary plan's benefit payment and 100% of our allowable charge, subject to our applicable deductibles, coinsurance and copayments (see pages 43-44 for exceptions when Medicare is primary payer). Thus, the combined payments from both plans may not equal the entire amount billed by the provider. In certain circumstances when we are secondary, and there is no adverse effect on you, we may also take advantage of any provider discount arrangements the primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan. When we are secondary to primary coverage you may have from a prepaid plan, our benefits will be based on your out-of-pocket liability under the prepaid plan (generally the prepaid plan's copayment) subject to our deductibles, coinsurance, and copayments (see page 44 for exceptions.)

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

When others are responsible for injuries

This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. We have the right to recover payments we have made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to our right of recovery, we are subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse us for benefits we paid in an amount not to exceed the amount of the recovery; and 2) that we will be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse us for benefits paid. Our share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless we agree in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, we shall have a lien on the proceeds of that claim in order to reimburse ourselves to the full amount of benefits we are called upon to pay. Our lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) we will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice our ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist us in any recovery; 2) our right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) we may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify us promptly of any third party claim that you may have for damages for which we have paid or may pay benefits. In addition, you are required to notify us of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse us to the extent of benefits paid by us. Any reduction of our claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by us.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Overpayments

We will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called **the equivalent Medicare amount**. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the provider's agreement with the Local Plan specifies otherwise, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's **Standard Option** surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

Section 9. Fee-for-Service Facts

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and keep premiums under control by following the procedures specified in this subsection.

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. **It is your responsibility to ensure that precertification is obtained.** If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500. When you call to obtain precertification, be sure also to verify whether the hospital is a Preferred, Member or Non-member hospital.

To precertify a scheduled admission:

- You, your representative, your physician, or your hospital must call the Local Plan prior to admission.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date, and phone number; reason for hospitalization, proposed treatment, or surgery; name of hospital or facility; name and phone number of admitting physician; and number of planned days of confinement.

The Local Plan will then tell the physician and/or hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the certification decision will be sent to you, your physician, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Need additional days?

If any additional days are required, your physician or the hospital must request certification for the additional days. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined not to be medically necessary by the Carrier during the claim review.

You don't need to precertify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 43 and 45). **Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.**
- You are confined in a hospital outside the United States.

Emergency admissions

When there is an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone the Local Plan within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by $500.

Maternity admissions

Precertification is **not** required for maternity admissions for routine deliveries. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, your physician or the hospital must contact the Local Plan for certification of additional days. The Plan will not pay for charges incurred on any extra days that are not medically necessary. Certification for additional days must also be requested for a covered newborn confined beyond the mother's discharge date.

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Local Plan unless the Local Plan is misled by the information given to it. After the claim is received, the Local Plan will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following the day of an emergency admission), a medical necessity determination will be made at the time the claim is filed. If the Local Plan determines that the hospitalization was not medically necessary, the inpatient hospital benefits will not be paid. **However, medical supplies and services otherwise payable on an outpatient basis will be paid.**

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by $500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

Prior approval

Before the following services are rendered, you or your provider should contact 1) the Local Plan where the services will be rendered, 2) the Retail Pharmacy Program for certain drugs and supplies, or 3) the Carrier for the clinical trials benefit for certain organ/tissue transplant procedures, for information and procedures for prior approval.

- **Home health care (High Option)**—The Local Plan will request the medical evidence it needs to make its coverage determination (see page 32).
- **Home hospice care**—The Local Plan will request the medical evidence it needs to make its coverage determination (see page 33).
- **Organ/tissue transplants**—The Local Plan will request the medical evidence it needs to make its coverage determination. The Local Plan will consider whether the facility is approved for the procedure and whether the patient meets the facility's criteria (see page 19).
- **Clinical trials for certain organ/tissue transplants**—The Carrier will request the records it needs to make its coverage determination. Inquiries and prior approval requests should be directed to the Clinical Trials Information Unit of the Blue Cross and Blue Shield Association at 1-800/225-2268 (see page 19). This number is for prior approval of clinical trials for bone marrow and peripheral blood stem cell transplant support procedures for multiple myeloma, breast cancer, epithelial ovarian cancer, chronic myelogenous leukemia, chronic lymphocytic leukemia, and early stage (indolent or non-advanced) small cell lymphocytic lymphoma only.

- **Prescription drugs and supplies**—The Retail Pharmacy Program will request the medical evidence it needs to make its coverage determination. Drugs and supplies that require prior approval also require 1) payment in full at time of purchase (including Preferred pharmacies) and 2) the member's submission of the expense(s) on a claim form. Preferred pharmacies will not file these expenses for you.

Protection Against Catastrophic Costs

Catastrophic protection

For services with coinsurance or copayments (other than those shown below as excluded from this Catastrophic Protection Benefit), you pay nothing for Covered charges for the remainder of the calendar year if out-of-pocket expenses for certain coinsurance, copayments, the calendar year deductible, and per admission deductibles in that calendar year exceed $2,700 (**High Option**) or $3,750 (**Standard Option**) for you and any covered family members.

Preferred providers

When your eligible out-of-pocket expenses, as discussed above, from using Preferred providers (when the services are eligible to be received from Preferred providers) exceed $1,000 (**High Option**) or $2,000 (**Standard Option**), you pay nothing for Covered charges for covered expenses when you continue to select Preferred providers for the remainder of the calendar year. Whether or not you use Preferred providers, your share of out-of-pocket expenses will not exceed $2,700 (**High Option**) or $3,750 (**Standard Option**) in a calendar year.

Out-of-pocket expenses

Out-of-pocket expenses for the purposes of this benefit are:

- The calendar year deductible of $150 (**High Option**) or $200 (**Standard Option**);
- The per admission deductible of $100 (**High Option**) or $250 (**Standard Option**) you pay for inpatient Non-preferred hospital care;
- The $10 (**High Option**) and $25 (**Standard Option**) copayments that you pay for outpatient facility care and outpatient facility surgical care in Preferred facilities under Other Medical Benefits;
- The $50 (**High Option**) and $100 (**Standard Option**) copayments that you pay for outpatient facility care and outpatient facility surgical care in Member facilities under Other Medical Benefits;
- The 5% PPA **(High Option)** and 10% PPA **(Standard Option)** coinsurance you pay for care provided by Preferred physicians, the 20% PAR (**High Option**) and 25% PAR (**Standard Option**) coinsurance you pay for care provided by Participating physicians, and the 20% NPA (**High Option**) and 25% NPA (**Standard Option**) coinsurance you pay for care provided by Non-participating physicians and other covered professionals under Inpatient Hospital Benefits, Surgical Benefits, Maternity Benefits, and Other Medical Benefits;
- The $12 copayment (under **High** and **Standard Options**) that you pay for each home and office visit, physician's outpatient consultation, and second surgical opinion when provided by a Preferred physician under Other Medical Benefits, Physician care, or each preventive (screening) physical examination when provided by a Preferred physician or Preferred facility under Additional Benefits, Preventive services provided by Preferred providers;
- The 15% PPA (**High Option**) and 25% PPA (**Standard Option**) coinsurance you pay for pharmacy-obtained drugs when provided by a Preferred pharmacy, and 35% AWP (**High Option**) and 45% AWP (**Standard Option**) coinsurance you pay for pharmacy-obtained drugs when provided by a Non-preferred pharmacy under Prescription Drug Benefits; and
- Mail Service Prescription Drug copayments.

The following expenses are not included under this Catastrophic Protection Benefit. They are not counted toward eligible out-of-pocket expenses and are not payable by the Plan when the Catastrophic Protection Benefit out-of-pocket limits have been reached:

- Expenses in excess of Allowable charges or maximum benefit limitations;
- The 30% of the Non-member rate coinsurance you pay for Non-member inpatient facility care;
- The $100 (**High Option**) and $150 (**Standard Option**) copayments you pay for Non-member outpatient facility care;
- Expenses for Mental Conditions/Substance Abuse Benefits or Dental Benefits; and

- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 47-48).

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the covered out-of-pocket maximum expense level in full, your old plan's catastrophic protection benefit will continue to apply until the effective date. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

If you change options in this Plan during the calendar year, the amounts already accumulated toward the PPO and Non-PPO catastrophic protection out-of-pocket limits of your old option will be credited to the out-of-pocket limits of your new option.

Definitions

Accidental injury

An injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings.

Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth. Injury to the teeth while eating is not considered an accidental injury.

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Allowable charge

See Covered charges.

Anesthesia service

The administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness.

Assignment

An authorization by an enrollee or spouse for the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member directly for all covered services.

Average charge

See Covered charges.

Average Wholesale Price (AWP)

See Covered charges.

Billed charge

See Covered charges.

Calendar year

January 1 through December 31 of the same year. For new members, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Carrier

The Blue Cross and Blue Shield Association, on behalf of local Blue Cross and Blue Shield Plans.

Collateral visit

A session to confirm the patient's diagnosis and establish a treatment plan and, during the course of treatment, to evaluate the patient's response to treatment.

Concurrent care

Hospital inpatient care by a physician other than the attending physician 1) for a condition not related to the primary diagnosis, or 2) because the medical complexity of the patient's condition requires additional medical care.

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Covered charges

Charges for covered services. The following are considered Covered charges:

Allowable charge—There are four types of Allowable charges: the Preferred Provider Allowance (PPA), which applies to charges from Preferred professionals and pharmacies; the Participating Provider Allowance (PAR), which applies to charges from Participating professional providers; the Non-participating Provider Allowance (NPA), which applies to charges from Non-participating professional providers; and the Average Wholesale Price (AWP), which applies to charges from Non-preferred pharmacies. If you are age 65 or older and not enrolled in Medicare, this may not apply (see pages 46-47). The definition of each Allowable charge is:

- **—Preferred Provider Allowance (PPA)—**A negotiated allowance most Preferred professionals and pharmacies agree to accept as payment in full, when the Plan pays primary benefits. (See pages 10-11 for information about Preferred physicians and acceptance of the Preferred Provider Allowance in your Local Plan area.)
- **—Participating Provider Allowance (PAR)—**A negotiated allowance most Participating professionals agree to accept as payment in full, when the Plan pays primary benefits. (See pages 10-11 for information about Participating physicians and acceptance of the Participating Provider Allowance in your Local Plan area.)
- **—Non-participating Provider Allowance (NPA)—**An allowance equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the Billed charge if there is no equivalent Medicare fee schedule amount) or 2) 80% of the 2000 Usual, Customary and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained.

  —Usual, Customary and Reasonable (UCR)—

  Profile: Local Plans determine reimbursement for covered services by applying a profile. The profile is developed from the actual charges by providers in their area. The profiles are generally updated annually; however, local exceptions may apply.

  Accepted allowance: Local Plans may determine reimbursement for covered expenses based on an accepted allowance instead of a profile. Accepted allowances are based on what Participating providers are accepting as payment in full in the Local Plan area.

  Non-participating physicians and other Non-participating providers are under no obligation to accept the Plan's allowance as payment in full. If you use Non-participating providers, you will be responsible for the difference between the Plan's payment and the provider's charge, including any applicable copayments, coinsurance, or deductibles.
- **—Average Wholesale Price (AWP)—**The average wholesale price of a drug on the date the drug is dispensed, as set forth in the most current version of First DataBank's National Drug Data File.

  Non-preferred pharmacies are under no obligation to accept the Plan's allowance as payment in full. If you use Non-preferred pharmacies, you will be responsible for the difference between the Plan's payment and the pharmacy's charge, including applicable coinsurance and deductibles.

- **Average charge—**An amount established by the Local Plan for a Non-member facility, not to exceed the average semiprivate rate charged by similar institutions in the same area for inpatient care. A Non-member facility is not required to accept the Average charge as payment in full.
- **Billed charge—**Charges for covered services billed by a provider (but see "If provider waives your share" on page 8). This amount may be different from the total amount submitted by the provider because it does not include charges for noncovered services.

- **Member rate—**The negotiated amount of payment that the Local Plan has agreed is due to a Member facility from the Plan and the enrollee for a claim at the time the claim is processed, including any savings the Local Plan receives from discounts that are known and that can be accurately calculated at the time the claim is processed. The Member rate may be subject to a periodic adjustment that generally, but not always, decreases the negotiated amount of payment due to the facility for the claim. If the payment is decreased, the amount of the decrease is credited to the reserves held for this Plan. If the payment is increased, the Plan pays that cost on behalf of the enrollee.
- **Non-member rate—**The Billed charge or the Average charge (see page 51).
- **Preferred rate—**The negotiated amount of payment that the Local Plan has agreed is due to a Preferred facility from the Plan and the enrollee for a claim at the time the claim is processed, including any savings the Local Plan receives from discounts that are known and that can be accurately calculated at the time the claim is processed. The Preferred rate may be subject to a periodic adjustment that generally, but not always, decreases the negotiated amount of payment due to the facility for the claim. If the payment is decreased, the amount of the decrease is credited to the reserves held for this Plan. If the payment is increased, the Plan pays that cost on behalf of the enrollee.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
2) homemaking, such as preparing meals or special diets;
3) moving the patient;
4) acting as companion or sitter;
5) supervising medication that can usually be self-administered; or
6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier, its medical staff and/or an independent medical review determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

1) are prescribed by your physician;
2) are medically necessary;
3) are primarily and customarily used only for a medical purpose;
4) are generally useful only to a person with an illness or injury;
5) are designed for prolonged use; and
6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The date the benefits described in this brochure are effective:

1) January 1 for continuing enrollments and for all annuitant enrollments; or
2) for enrollees who change plans or options or elect FEHB coverage during the open season for the first time and for new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system.

Enrollee

The contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan.

Experimental or investigational

See page 12.

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Home health care

Medical care provided to homebound patients who require continuous, active and skilled care at home.

Home health care agency

An organization that has a written agreement with the Local Plan to provide home health care services.

Home hospice care program

An integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients in their homes.

Lifetime maximum

The maximum amount the Plan will pay on your behalf for covered services rendered while you are enrolled in your option. Benefit amounts accrued under **High Option** and **Standard Option** are accumulated in a permanent record regardless of the number of enrollment changes.

Local Plan

A Blue Cross and Blue Shield Plan serving a specific geographic area.

Medically necessary

Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that the Carrier determines:

1) are appropriate to diagnose or treat the patient's condition, illness or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4) are not a part of or associated with the scholastic education or vocational training of the patient; and
5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug, or equipment does not, in itself, make it medically necessary.

Member rate

See Covered charges.

Members

Enrollees and family members eligible for coverage under the Federal Employees Health Benefits Program and enrolled in the Plan.

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by the Carrier; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Non-member rate

See Covered charges.

Non-participating physician

A Non-participating physician does not have an agreement with the local Blue Shield Plan. Payment can be made to the physician or to the member, at the Local Plan's option. The member is responsible for the balance, if any, between the Local Plan's payment and the physician's charge.

Non-participating Provider Allowance (NPA)

See Covered charges.

Participating physician

A Participating physician is one who, at the time a covered service is rendered, has a written agreement with the local Blue Shield Plan; payment is made to the Participating physician based on a negotiated allowance (PAR, see Covered charges) agreed to between the Participating physician and the Local Plan.

Participating Provider Allowance (PAR)

See Covered charges.

Plan

The Blue Cross and Blue Shield Service Benefit Plan.

Precertification

The requirement to contact the Local Plan serving the area where the services will be rendered before being admitted to a hospital for inpatient care, or within two business days following the admission when the hospital admission is an emergency.

Preferred physician

A Preferred physician is one who, at the time a covered service is rendered, has a written agreement with the local Blue Shield Plan; payment is made to the Preferred physician based on a negotiated allowance (PPA, see Covered charges) agreed to between the Preferred physician and the Local Plan.

Preferred Provider Allowance (PPA)

See Covered charges.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, or other health care professionals (or for pharmacies, PCS Health Systems, Inc.) to provide services to you at a reduced cost. The PPO (also known as the Preferred Provider Program—PPP) provides members the opportunity to reduce their out-of-pocket expenses for care by selecting facilities and providers from among a specific group of health care providers. Preferred providers are available in most locations; your use of them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, PCS Health Systems, Inc.) responsibility; continued participation of any specific PPO provider cannot be guaranteed.

Preferred rate

See Covered charges.

Prior approval

Written assurance that benefits will be provided from 1) the Local Plan where the services will be rendered, 2) the Retail Pharmacy Program or the Mail Service Prescription Drug Program for prescription drugs and supplies, or 3) the Carrier for the clinical trials benefit for certain organ/tissue transplant procedures. Home health care, home hospice care, certain drugs and supplies, and certain organ/tissue transplant procedures require prior approval. For further information, see pages 48-49.

Prosthetic appliance

A device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care.

Sound natural tooth

A tooth that is whole or properly restored (restoration by amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth with a crown is not considered a sound natural tooth.

Section 10. FEHB Facts

You have a right to the following information.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call or write to us at the telephone number and/or address listed on the back of your ID card, or visit our website at (www.fepblue.org).

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a Guide to Federal Employees Health Benefits Plans, brochures for other plans and other material you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- The next Open Season for enrollment.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I retire?

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage, which is described later in this section.

What types of coverage are available for me and my family?

Self-Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster or step-children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who became incapable of self-support before age 22.

If you have a Self-Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in another FEHB plan.

Are my medical and claims records confidential?

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and our subcontractors when they administer this contract;
- This plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or

- OPM, when reviewing a disputed claim or defending litigation about a claim.
- As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive you ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

We will not refuse to cover the treatment of a condition that you or a family member had before you enrolled in this Plan solely because you had the condition before you enrolled.

When you lose benefits

What happens if my enrollment in this Plan ends?

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for former spouse coverage or Temporary Continuation of Coverage.

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees from your employing or retirement office.

Key points about TCC:

- You can pick a new plan.
- If you leave Federal service, you can receive TCC for up to 18 months after you separate.
- If you no longer qualify as a family member, you can receive TCC for up to 36 months.
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert.
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

The National Defense Authorization Act for 1999, Public law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible?

DoD determines who is eligible to enroll in the FEHBP. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare,
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare,
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried, or
- You are a survivor dependent of a deceased active or retired uniformed service member, and
- You live in one of the eight geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

Where are the demonstration areas?

- Dover AFB, DE
- Commonwealth of Puerto Rico
- Fort Knox, KY
- Greensboro/Winston Salem/High Point, NC
- Dallas, TX
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- New Orleans, LA

When can I join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (self-only) or for you and your family (self and family) during the 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

If you become eligible for the DoD/FEHBP Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," on the OPM web site at www.opm.gov.

Am I eligible for Temporary Continuation of Coverage (TCC)?

See Section 10, FEHB Facts, for information about TCC. Under this Demonstration Project the only individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHBP Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHBP Demonstration Project.

TCC is not available if you move out of a DoD/FEHBP Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Do I have the 31-day extension and right to convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800/FEP-8440 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U. S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and is not an official statement of benefits.

Notes

Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan High Option—2000

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $150 per person ($300 per family) calendar year deductible. This Plan has two options; a summary of benefits for the **Standard Option** is located on page 63 of this brochure.

	Benefits	High Option Pays	Page
Inpatient care	**Hospital**	**PPO benefit:** You pay nothing for unlimited days **Non-PPO benefit:** After $100 per admission deductible, you pay nothing for unlimited days	15
	Surgical	**PPO benefit:** You pay 5% PPA for physician services **Non-PPO benefit:** You pay 20% Allowable charge for physician services	17-20
	Medical	**PPO benefit:** You pay 5% PPA for physician medical care **Non-PPO benefit:** You pay 20% Allowable charge for physician medical care	16
	Maternity	**PPO benefit:** You pay nothing for physician obstetrical care **Non-PPO benefit:** Same benefits as for illness or injury	21-23
	Mental Conditions	Covered charges up to 120 days per calendar year; you pay 20%* Allowable charge for inpatient physician care **PPO benefit:** You pay up to $75 per day for the first 120 days; you pay all charges thereafter **Non-PPO benefit:** You pay up to $150 per day in Member hospitals and up to $300 per day in Non-member hospitals for the first 120 days per calendar year; you pay all charges thereafter	24
	Substance Abuse	One treatment program (28-day maximum) per lifetime	25
Outpatient care	**Hospital**	**PPO benefit:** You pay up to $10 per day in connection with outpatient surgery; you pay up to $10* per day for other outpatient care not related to outpatient surgery or accidental injury care **Non-PPO benefit:** You pay up to $50 per day at Member facilities, and up to $100 per day at Non-member facilities, in connection with outpatient surgery; you pay up to $50* per day at Member facilities, and up to $100* per day at Non-member facilities, for other outpatient care not related to outpatient surgery or accidental injury care	26-27, 32
	Surgical	**PPO benefit:** You pay 5% PPA for physician services **Non-PPO benefit:** You pay 20% Allowable charge for physician services	17-20
	Medical	**PPO benefit:** You pay a $12 copayment per covered visit **Non-PPO benefit:** For home and office visits, you pay 20%* Allowable charge	27-28
	Maternity	**PPO benefit:** You pay nothing for physician obstetrical care **Non-PPO benefit:** Same benefits as for illness or injury	21-23
	Home Health Care	You pay nothing for home health care agency charges up to 90 days per calendar year (Also see page 29 for Home nursing care benefit.)	32
	Mental Conditions/ Substance Abuse	**PPO benefit:** You pay up to $10* per day at Preferred facilities for outpatient facility care **Non-PPO benefit:** You pay up to $50* per day at Member facilities, and up to $100* per day at Non-member facilities, for outpatient facility care; you pay 30%* Allowable charge for outpatient professional care for mental conditions/substance abuse, up to 50 visits per calendar year	25
Emergency care (Outpatient accidental injury care)		You pay nothing for hospital and physician services rendered within 72 hours of injury	32
Prescription drugs		**PPO benefit:** (Retail Pharmacy Program) You pay 15% PPA	34
		Non-PPO benefit: (Retail Pharmacy Program) You pay 35% Average Wholesale Price (AWP)	34
		Mail Service Prescription Drug Program: You pay an $8 generic and $14 brand-name per prescription copay	35
Dental care		Dental services required due to accidental injury; and covered oral and maxillofacial surgery	19, 29
Additional benefits		Preventive services provided by **PPO** providers, Home hospice care, Well child care, and Skilled nursing facility care	31-33
Protection against catastrophic costs		You pay nothing for Covered charges when applicable coinsurance and deductibles reach $1,000 per contract in a calendar year when **PPO** providers are used and $2,700 when they are not	49

Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option—2000

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $200 per person ($400 per family) calendar year deductible. This Plan has two options; a summary of benefits for the **High Option** is located on page 62 of this brochure.

	Benefits	Standard Option Pays	Page
Inpatient care	**Hospital**	**PPO benefit:** You pay nothing for unlimited days **Non-PPO benefit:** After $250 per admission deductible, you pay nothing for unlimited days	15
	Surgical	**PPO benefit:** You pay 10%* PPA for physician services **Non-PPO benefit:** You pay 25%* Allowable charge for physician services	17-20
	Medical	**PPO benefit:** You pay 10%* PPA for physician medical care **Non-PPO benefit:** You pay 25%* Allowable charge for physician medical care	16
	Maternity	**PPO benefit:** You pay nothing for physician obstetrical care **Non-PPO benefit:** Same benefits as for illness or injury	21-23
	Mental Conditions	Covered charges up to 100 days per calendar year; you pay 40%* Allowable charge for inpatient physician care **PPO benefit:** You pay up to $150 per day for the first 100 days; you pay all charges thereafter **Non-PPO benefit:** You pay up to $250 per day in Member hospitals and up to $400 per day in Non-member hospitals for the first 100 days per calendar year; you pay all charges thereafter	24
	Substance Abuse	One treatment program (28-day maximum) per lifetime	25
Outpatient care	**Hospital**	**PPO benefit:** You pay up to $25 per day in connection with outpatient surgery; you pay up to $25* per day for other outpatient care not related to outpatient surgery or accidental injury care **Non-PPO benefit:** You pay up to $100 per day at Member facilities, and up to $150 per day at Non-member facilities, in connection with outpatient surgery; you pay up to $100* per day at Member facilities, and up to $150* per day at Non-member facilities, for other outpatient care not related to outpatient surgery or accidental injury care	26-27, 32
	Surgical	**PPO benefit:** You pay 10%* PPA for physician services **Non-PPO benefit:** You pay 25%* Allowable charge for physician services	17-20
	Medical	**PPO benefit:** You pay a $12 copayment per covered visit **Non-PPO benefit:** You pay 25%* Allowable charge for home and office visits	27-28
	Maternity	**PPO benefit:** You pay nothing for physician obstetrical care **Non-PPO benefit:** Same benefits as for illness or injury	21-23
	Home Health Care	No current Home health care benefit (See page 29 for Home nursing care benefit.)	32
	Mental Conditions/ Substance Abuse	**PPO benefit:** You pay up to $25* per day at Preferred facilities for outpatient facility care **Non-PPO benefit:** You pay up to $100* per day at Member facilities, and up to $150* per day at Non-member facilities, for outpatient facility care; you pay 40%* Allowable charge for outpatient professional care for mental conditions/substance abuse, up to 25 visits per calendar year	25
Emergency care (Outpatient accidental injury care)		You pay nothing for hospital and physician services rendered within 72 hours of injury	32
Prescription drugs		**PPO benefit:** (Retail Pharmacy Program) You pay 25% PPA	34
		Non-PPO benefit: (Retail Pharmacy Program) You pay 45% Average Wholesale Price (AWP)	34
		Mail Service Prescription Drug Program: You pay a $12 generic and $20 brand-name per prescription copay	35
Dental care		Fee schedule allowances for diagnostic and preventive services, fillings, and extractions. Higher level fee schedule allowances for children up to age 13; dental services required due to accidental injury; and covered oral and maxillofacial surgery	19, 29, 36-37
Additional benefits		Preventive services provided by **PPO** providers, Home hospice care, Well child care, and Skilled nursing facility care	31-33
Protection against catastrophic costs		You pay nothing for Covered charges when applicable coinsurance and deductibles reach $2,000 per contract in a calendar year when **PPO** providers are used and $3,750 when they are not	49

2000 Rate Information for Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career employee who is not a member of a special postal employment class, refer to the category definitions in The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees, RE 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable Guide to Federal Employees Health Benefits Plans.

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	**Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**USPS Share**	**Your Share**	**USPS Share**	**Your Share**
High Option Self Only	**101**	**$78.83**	**$66.29**	**$170.80**	**$143.63**	**$93.06**	**$52.06**	**$93.26**	**$51.86**
High Option Self and Family	**102**	**$175.97**	**$134.35**	**$381.27**	**$291.09**	**$207.74**	**$102.58**	**$201.02**	**$109.30**
Standard Option Self Only	**104**	**$78.83**	**$30.04**	**$170.80**	**$65.09**	**$93.06**	**$15.81**	**$93.26**	**$15.61**
Standard Option Self and Family	**105**	**$175.97**	**$66.78**	**$381.27**	**$144.69**	**$207.74**	**$35.01**	**$201.02**	**$41.73**